MEDICARE RECONCILIATION PROVISIONS

AS REPORTED BY COMMITTEE ON COMMERCE

ON JUNE 12, 1997

TITLE IV—COMMITTEE ON COMMERCE—MEDICARE

SEC. 4000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(c) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

Subtitle A—MedicarePlus Program

CHAPTER 1—MEDICAREPLUS PROGRAM

Subchapter A—MedicarePlus Program

SEC. 4001. ESTABLISHMENT OF MEDICAREPLUS PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

"PART C—MEDICAREPLUS PROGRAM

"ELIGIBILITY, ELECTION, AND ENROLLMENT

"SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREPLUS PLANS.—

"(1) IN GENERAL.—Subject to the provisions of this section, each MedicarePlus eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

"(A) through the medicare fee-for-service program under parts A and B, or

"(B) through enrollment in a MedicarePlus plan under this part.

"(2) TYPES OF MEDICAREPLUS PLANS THAT MAY BE AVAILABLE.—A MedicarePlus plan may be any of the following types of plans of health insurance:

"(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including

health maintenance organization plans and preferred provider organization plans.

"(B) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A MedicarePlus plan offered by a provider-sponsored organization, as defined in section 1855(e).

"(C) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREPLUS MSA.—An MSA plan, as defined in section 1859(b)(2), and a contribution into a MedicarePlus medical savings account (MSA).

"(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—In this title, subject to subparagraph (B), the term 'MedicarePlus eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a MedicarePlus plan may continue to be enrolled in that plan.

"(b) SPECIAL RULES.—

"(1) RESIDENCE REQUIREMENT.—

"(A) IN GENERAL.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization serves the geographic area in which the individual resides.

"(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

"(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS .—

"(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

"(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

"(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

"(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

"(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

"(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

"(ii) as of any date if the number of such individuals so enrolled as of such date has reached 500,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

"(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

"(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

"(c) PROCESS FOR EXERCISING CHOICE.—

"(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

"(2) COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.—

"(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus plan offered by a MedicarePlus organization to make such

election through the filing of an appropriate election form with the organization.

"(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicarePlus plan offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

"(3) DEFAULT.—

"(A) INITIAL ELECTION.—

"(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the medicare fee-for-service program option.

"(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than MedicarePlus plan) offered by a MedicarePlus organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

"(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

"(i) the individual changes the election under this section, or

"(ii) a MedicarePlus plan is discontinued, if the individual had elected such plan at the time of the discontinuation./

"(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

"(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

"(2) PROVISION OF NOTICE.—

"(A) OPEN SEASON NOTIFICATION.—At least 30 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicarePlus eligible individual residing in an area the following:

"(i) GENERAL INFORMATION.—The general information described in paragraph (3).

"(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicarePlus plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

"(iii) MEDICAREPLUS MONTHLY CAPITATION RATE.—The amount of the monthly MedicarePlus capitation rate for the area.

"(iv) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

"(B) NOTIFICATION TO NEWLY MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 2 months before the beginning of the initial MedicarePlus enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

"(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

"(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicarePlus plans and the benefits and monthly premiums (and net monthly premiums) for such plans.

"(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

"(A) BENEFITS UNDER FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered (and not covered) under the medicare fee-for-service program under parts A and B, including—

"(i) covered items and services,

"(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

"(iii) any beneficiary liability for balance billing.

"(B) PART B PREMIUM.—The part B premium rates that will be charged for part B coverage.

"(C) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

"(D) RIGHTS.—The general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the medicare fee-for-service program and the MedicarePlus program and right to be protected against discrimination based on health status-related factors under section 1852(b).

"(E) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and pro-

visions relating to medicare select policies described in section 1882(t).

''(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicarePlus organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the MedicarePlus plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicarePlus plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered (and not covered) under the plan, including—

''(i) covered items and services beyond those provided under the medicare fee-for-service program,

''(ii) any beneficiary cost sharing,

''(iii) any maximum limitations on out-of-pocket expenses,

''(iv) in the case of an MSA plan, differences in cost sharing under such a plan compared to under other MedicarePlus plans,

''(v) the use of provider networks and the restriction on payments for services furnished other than by other through the organization,

''(vi) the organization's coverage of emergency and urgently needed care,

''(vii) the appeal and grievance rights of enrollees,

''(viii) number of grievances and appeals, and information on their disposition in the aggregate,

''(ix) procedures used by the organization to control utilization of services and expenditures, and

''(x) any exclusions in the types of providers participating in the plan's network.

''(B) PREMIUMS.—The monthly premium (and net monthly premium), if any, for the plan.

"(C) SERVICE AREA.—The service area of the plan.

"(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the medicare fee-for-service program under parts A and B in the area involved), including—

"(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

"(ii) information on medicare enrollee satisfaction,

"(iii) information on health outcomes, and

"(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

"(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

"(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of this part in all areas in which MedicarePlus plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicarePlus plans.

"(6) USE OF NONFEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

"(7) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

"(e) COVERAGE ELECTION PERIODS.—

"(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREPLUS PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more MedicarePlus plans offered in the area in which the individual resides, the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at such time. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

"(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

"(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2000.—At any time during 1998, 1999, and 2000, a MedicarePlus eligible individual may change the election under subsection (a)(1).

"(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2001.—

"(i) IN GENERAL.—Subject to clause (ii), at any time during the first 6 months of 2001, or, if the individual first becomes a MedicarePlus eligible individual during 2001, during the first 6 months during 2001 in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

"(ii) LIMITATION OF ONE CHANGE PER YEAR.—An individual may exercise the right under clause (i) only once during 2001. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

"(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

"(i) IN GENERAL.—Subject to clause (ii), at any time during the first 3 months of a year after 2001, or, if the individual first becomes a MedicarePlus eligible individual during a year after 2001, during the first 3 months of such year in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

"(ii) LIMITATION OF ONE CHANGE PER YEAR.—An individual may exercise the right under clause (i) only once a year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—

"(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

"(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 2001), the month of October before such year.

"(C) MEDICAREPLUS HEALTH FAIRS.—In the month of October of each year (beginning with 1998), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicarePlus eligible individuals about MedicarePlus plans and the election process provided under this section.

"(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2001, an individual may discontinue an election

of a MedicarePlus plan offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

"(A) the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

"(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

"(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

"(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

"(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

"(D) the individual meets such other exceptional conditions as the Secretary may provide.

"(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

"(A) may elect an MSA plan only during—

"(i) an initial open enrollment period described in paragraph (1),

"(ii) an annual, coordinated election period described in paragraph (3)(B), or

"(iii) the months of October 1998 and October 1999; and

"(B) may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under paragraph (4).

"(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

"(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

"(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

"(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

"(g) GUARANTEED ISSUE AND RENEWAL.—

"(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under this section with respect to a MedicarePlus plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

"(2) PRIORITY.—If the Secretary determines that a MedicarePlus organization, in relation to a MedicarePlus plan it offers, has a capacity limit and the number of MedicarePlus eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

"(A) first to such individuals as have elected the plan at the time of the determination, and

"(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

"(3) LIMITATION ON TERMINATION OF ELECTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under this section for a MedicarePlus plan it offers.

"(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual's election under this section with respect to a MedicarePlus plan it offers if—

"(i) any net monthly premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of net monthly premiums),

"(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

"(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

"(C) CONSEQUENCE OF TERMINATION.—

"(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the medicare fee-for-service program option described in subsection (a)(1)(A).

"(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicarePlus plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the medicare fee-for-service program option described in subsection (a)(1)(A).

"(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each MedicarePlus organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

"(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

"(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicarePlus organization to (or for the use of) MedicarePlus eligible individuals unless—

"(A) at least 45 days before the date of distribution the organization has submitted the material or form to the Secretary for review, and

"(B) the Secretary has not disapproved the distribution of such material or form.

"(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such

material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicarePlus plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

"(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicarePlus organization shall conform to fair marketing standards, in relation to MedicarePlus plans offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against a MedicarePlus organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

"(i) EFFECT OF ELECTION OF MEDICAREPLUS PLAN OPTION.—Subject to sections 1852(a)(5), 1857(f)(2), and 1857(g)—

"(1) payments under a contract with a MedicarePlus organization under section 1853(a) with respect to an individual electing a MedicarePlus plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual, and

"(2) subject to subsections (e) and (f) of section 1853, only the MedicarePlus organization shall be entitled to re-

ceive payments from the Secretary under this title for services furnished to the individual.

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Except as provided in section 1859(b)(2) for MSA plans, each MedicarePlus plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

''(B) additional benefits required under section 1854(f)(1)(A).

''(2) SATISFACTION OF REQUIREMENT.—A MedicarePlus plan (other than an MSA plan) offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(3) SUPPLEMENTAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicarePlus organization may provide to individuals enrolled under this part (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by MedicarePlus eligible individuals with the organization.

"(B) AT ENROLLEES' OPTION.—A MedicarePlus organization may provide to individuals enrolled under this part (other than under an MSA plan) supplemental health care benefits that the individuals may elect, at their option, to have covered.

"(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under a MedicarePlus plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such a law, plan, or policy—

"(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

"(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

"(5) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicarePlus organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual MedicarePlus capitation rate under section 1853 included in the announcement made at the beginning of such period—

"(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

"(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to

payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

''(b) ANTIDISCRIMINATION.—

''(1) IN GENERAL.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(2) CONSTRUCTION.—Paragraph (1) shall not be construed as requiring a MedicarePlus organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

''(c) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicarePlus organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicarePlus plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(1) SERVICE AREA.—The plan's service area.

''(2) BENEFITS.—Benefits offered (and not offered) under the plan offered, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicarePlus plans.

''(3) ACCESS.—The number, mix, and distribution of plan providers and any point-of-service option (including the supplemental premium for such option).

''(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(5) EMERGENCY COVERAGE.—Coverage of emergency services and urgently needed care, including—

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local

equivalent in emergency situations and an explanation of what constitutes an emergency situation;

"(B) the process and procedures of the plan for obtaining emergency services; and

"(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care..

"(6) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

"(A) whether the supplemental benefits are optional,

"(B) the supplemental benefits covered, and

"(C) the premium price for the supplemental benefits.

"(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

"(8) PLAN GRIEVANCE AND APPEALS PROCEDURES.—Any appeal or grievance rights and procedures.

"(9) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

"(d) ACCESS TO SERVICES.—

"(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus plan may select the providers from whom the benefits under the plan are provided so long as—

"(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

"(B) when medically necessary in the opinion of the treating health care provider the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

"(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

"(i) the services were medically necessary in the opinion of the treating health care provider and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization,

"(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

"(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

"(D) the organization provides access to appropriate providers, including credentialed specialists, for treatment and services when such treatment and services are determined to be medically necessary in the professional opinion of the treating health care provider, in consultation with the individual; and

"(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

"(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicarePlus plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

"(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

"(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

"(i) are furnished by a provider that is qualified to furnish such services under this title, and

"(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

"(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(4) DETERMINATION OF HOSPITAL LENGTH OF STAY.—

"(A) IN GENERAL.—A MedicarePlus organization shall cover the length of an inpatient hospital stay under this part as determined by the attending physician (or other attending health care provider to the extent permitted under State law) in consultation with the patient to be medically appropriate.

"(B) CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) as requiring the provision of inpatient coverage if the attending physician (or other attending health care provider to the extent permitted under

State law) and patient determine that a shorter period of hospital stay is medically appropriate, or

"(ii) as affecting the application of deductibles and coinsurance.

"(e) QUALITY ASSURANCE PROGRAM.—

"(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicarePlus plans of the organization.

"(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

"(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicarePlus plans and organizations;

"(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

"(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

"(D) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

"(E) evaluate the continuity and coordination of care that enrollees receive;

"(F) have mechanisms to detect both underutilization and overutilization of services;

"(G) after identifying areas for improvement, establish or alter practice parameters;

"(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

"(I) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

"(J) be evaluated on an ongoing basis as to its effectiveness;

"(K) include measures of consumer satisfaction; and

"(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

"(3) EXTERNAL REVIEW.—Each MedicarePlus organization shall, for each MedicarePlus plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by MedicarePlus plans for which payment is made under this title.

"(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet requirements of paragraphs (1) through (3) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

"(f) COVERAGE DETERMINATIONS.—

"(1) DECISIONS ON NONEMERGENCY CARE.—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

The organization shall provide notice of any coverage denial, which notice shall include a statement of the reasons for the denial and a description of the grievance and appeals processes available.

"(2) RECONSIDERATIONS.—

"(A) IN GENERAL.—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

"(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

"(g) GRIEVANCES AND APPEALS.—

"(1) GRIEVANCE MECHANISM.—Each MedicarePlus organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicarePlus plans of the organization under this part.

"(2) APPEALS.—An enrollee with a MedicarePlus plan of a MedicarePlus organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and

both the individual and the organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) INDEPENDENT REVIEW OF COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage.

''(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—An enrollee in a MedicarePlus plan may request, either in writing or orally, an expedited determination or reconsideration by the MedicarePlus organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The MedicarePlus organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) TIMELY RESPONSE.—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration)

of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

"(iii) SECRETARIAL REPORT.—The Secretary shall annually report publicly on the number and disposition of denials and appeals within each MedicarePlus organization, and those reviewed and resolved by the independent entities under this subsection.

"(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

"(1) to safeguard the privacy of individually identifiable enrollee information,

"(2) to maintain accurate and timely medical records and other health information for enrollees, and

"(3) to assure timely access of enrollees to their medical information.

"(i) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicarePlus organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

"(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

"(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus plans offered by the organization under this part. Such procedures shall include—

"(A) providing notice of the rules regarding participation,

"(B) providing written notice of participation decisions that are adverse to physicians, and

"(C) providing a process within the organization for appealing such adverse decisions, including the

presentation of information and views of the physician regarding such decision.

"(2) CONSULTATION IN MEDICAL POLICIES.—A MedicarePlus organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

"(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicarePlus organization (in relation to an individual enrolled under a MedicarePlus plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

"(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicarePlus plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan—

"(i) objects to the provision of such service on moral or religious grounds; and

"(ii) in the manner and through the written instrumentalities such MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

"(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

"(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicarePlus plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

"(4) LIMITATIONS ON HEALTH CARE PROVIDER INCENTIVE PLANS.—

"(A) IN GENERAL.—No MedicarePlus organization may operate any health care provider incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

"(i) No specific payment is made directly or indirectly under the plan to a health care provider or health care provider group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

"(ii) If the plan places a health care provider or health care provider group at substantial financial risk (as determined by the Secretary) for services not provided by the health care provider or health care provider group, the organization—

"(I) provides stop-loss protection for the health care provider or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of health care providers placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the health care provider or group, and

"(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

"(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

"(B) HEALTH CARE PROVIDER INCENTIVE PLAN DEFINED.—In this paragraph, the term 'health care provider incentive plan' means any compensation arrangement between a MedicarePlus organization and a health care provider or health care provider group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

"(C) HEALTH CARE PROVIDER DEFINED.—For the purposes of this paragraph, the term 'health care provider' has the meaning given the term 'health care professional' in paragraph (3)(D).

"(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with

a MedicarePlus plan of the organization under this part by the organization's denial of medically necessary care.

"(6) LIMITATION ON NON-COMPETE CLAUSE.—A MedicarePlus organization may not (directly or indirectly) seek to enforce any contractual provision which prevents a provider whose contractual obligations to the organization for the provision of services through the organization have ended from joining or forming any competing MedicarePlus organization that is a provider-sponsored organization in the same area.

"(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

"(l) DISCLOSURE OF USE OF DSH AND TEACHING HOSPITALS.—Each MedicarePlus organization shall provide the Secretary with information on—

"(1) the extent to which the organization provides inpatient and outpatient hospital benefits under this part—

"(A) through the use of hospitals that are eligible for additional payments under section 1886(d)(5)(F)(i) (relating to so-called DSH hospitals), or

"(B) through the use of teaching hospitals that receive payments under section 1886(h); and

"(2) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

"(m) OUT-OF-NETWORK ACCESS.—If an organization offers to members enrolled under this section one plan which provides for coverage of services covered under parts A and B primarily through providers and other persons who are members of a network of providers and other persons who have entered into a contract with the organization to provide such services, nothing in this section shall be construed as preventing the organization from offering such members (at the time of enrollment) another plan which provides for coverage of such items which are not furnished through such network providers.

"(n) NON-PREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to beneficiary protections in this section, but only if such requirements are more stringent than the requirements established under this section.

"(o) NONDISCRIMINATION IN SELECTION OF NETWORK HEALTH PROFESSIONALS.—

"(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus plan offering network coverage shall not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in such network) on the basis of the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the health professional.

"(2) APPROPRIATE RANGE OF SERVICES.—A MedicarePlus organization shall not deny any health care professionals, based solely on the license or certification as applicable under State law, the ability to participate in providing covered health care services, or be reimbursed or indemnified by a network plan for providing such services under this part.

"(2) DEFINITIONS.—For purposes of this subsection:

"(A) NETWORK.—The term 'network' means, with respect to a MedicarePlus organization offering a MedicarePlus plan, the participating health profes-

sionals and providers through whom the organization provides health care items and services to enrollees.

"(B) NETWORK COVERAGE.—The term 'network coverage' means a MedicarePlus plan offered by a MedicarePlus organization that provides or arranges for the provision of health care items and services to enrollees through participating health professionals and providers.

"(C) PARTICIPATING.—The term 'participating' means, with respect to a health professional or provider, a health professional or provider that provides health care items and services to enrollees under network coverage under an agreement with the MedicarePlus organization offering the coverage.

"(p) SPECIAL RULE FOR UNRESTRICTED FEE-FOR-SERVICE MSA PLANS.—Subsections (j)(1) and (k) shall not apply to a MedicarePlus organization with respect to an MSA plan it offers if the plan does not limit the providers through whom benefits may be obtained under the plan.

"PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

"SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

"(1) MONTHLY PAYMENTS.—

"(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to 1/12 of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicarePlus organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

"(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes

of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the information required to be disclosed under section 1852(c) at the time the individual enrolled with the organization.

"(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

"(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than October 1, 1999, a report on a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

"(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicarePlus organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

"(C) INITIAL IMPLEMENTATION.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

"(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

"(A) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and

"(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

"(c) CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.—

"(1) IN GENERAL.—For purposes of this part, each annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraphs (A), (B), or (C):

"(A) BLENDED CAPITATION RATE.—The sum of—

"(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

"(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-ad-

justed annual national MedicarePlus capitation rate for the year, as determined under paragraph (4), multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

"(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

"(i) For 1998, $350 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

"(ii) For a succeeding year, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita MedicarePlus growth percentage, specified under paragraph (6) for that succeeding year.

"(C) MINIMUM PERCENTAGE INCREASE.—

"(i) For 1998, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

"(ii) For 1999 and 2000, 101 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

"(iii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

"(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

"(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

"(B) for 1999, the 'area-specific percentage' is 85 percent and the 'national percentage' is 15 percent,

"(C) for 2000, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

"(D) for 2001, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent, and

"(E) for a year after 2001, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent.

"(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

"(i) for 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in paragraph (6)); or

"(ii) for a subsequent year is the annual area-specific MedicarePlus capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

"(B) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

"(i) IN GENERAL.—In determining the area-specific MedicarePlus capitation rate under subparagraph (A), for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

"(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

"(I) 1998 is 20 percent,

"(II) 1999 is 40 percent,

"(III) 2000 is 60 percent,

"(IV) 2001 is 80 percent, and

"(V) a succeeding year is 100 percent.

"(C) PAYMENT ADJUSTMENT.—The payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

"(i) under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients,

"(ii) for the indirect costs of medical education under section 1886(d)(5)(B), and

"(iii) for direct graduate medical education costs under section 1886(h),

multiplied by a ratio (estimated by the Secretary) of total payments under subsection (h) and section 1858 in 1998 to payments under such subsection and payments under such section in such year for hospitals not reimbursed under section 1814(b)(3).

"(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICAREPLUS CAPITATION RATE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

"(i) the national standardized annual MedicarePlus capitation rate (determined under subparagraph (B)) for the year,

"(ii) the proportion of such rate for the year which is attributable to such type of services, and

"(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary shall, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

"(B) NATIONAL STANDARDIZED ANNUAL MEDICAREPLUS CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual MedicarePlus capitation rate' for a year is equal to—

"(i) the sum (for all MedicarePlus payment areas) of the product of—

"(I) the annual area-specific MedicarePlus capitation rate for that year for the area under paragraph (3), and

"(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

"(ii) the sum of the products described in clause (i)(II) for all areas for that year.

"(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

"(i) medicare services shall be divided into 2 types of services: part A services and part B services;

"(ii) the proportions described in subparagraph (A)(ii)—

"(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

"(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

"(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

"(iv) for part B services—

"(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

"(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

"(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

"(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—For purposes of paragraph (1)(A)—

"(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B) but taking into account paragraph (7), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-

specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

"(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

"(6) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE DEFINED.—

"(A) IN GENERAL.—In this part, the 'national per capita MedicarePlus growth percentage' for a year is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease. Such percentage shall include an adjustment for over or under projection in the growth percentage for previous years.

"(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

"(i) for 1998, 0.5 percentage points,

"(ii) for 1999, 0.5 percentage points,

"(iii) for 2000, 0.5 percentage points,

"(iv) for 2001, 0.5 percentage points,

"(v) for 2002, 0.5 percentage points, and

"(vi) for a year after 2002, 0 percentage points.

"(7) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a MedicarePlus payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

"(d) MEDICAREPLUS PAYMENT AREA DEFINED.—

"(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'MedicarePlus payment area' means a county, or equivalent area specified by the Secretary.

"(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicarePlus payment area shall be a State or such other payment area as the Secretary specifies.

"(3) GEOGRAPHIC ADJUSTMENT.—

"(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a MedicarePlus payment area in the State otherwise determined under paragraph (1)—

"(i) to a single statewide MedicarePlus payment area,

"(ii) to the metropolitan based system described in subparagraph (C), or

"(iii) to consolidating into a single MedicarePlus payment area noncontiguous counties

(or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

"(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for MedicarePlus payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicarePlus payment areas in the State in the absence of the adjustment under this paragraph.

"(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

"(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicarePlus payment area, and

"(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicarePlus payment area.

"(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

"(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

"(1) IN GENERAL.—If the amount of the monthly premium for an MSA plan for a MedicarePlus payment area for a year is less than 1/12 of the annual MedicarePlus capi-

tation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

"(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

"(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicarePlus MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

"(B) if the individual has established more than one such MedicarePlus MSA, has designated one of such accounts as the individual's MedicarePlus MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

"(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicarePlus MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

"(f) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization and payments to a MedicarePlus MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Fed-

eral Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001.

"(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

"(1) election under this part of a MedicarePlus plan offered by a MedicarePlus organization—

"(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus plan or the medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

"(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

"(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

"(2) termination of election with respect to a MedicarePlus organization under this part—

"(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

"(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicarePlus organization, and

"(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''PREMIUMS

''SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

''(1) IN GENERAL.—Subject to paragraph (3), each MedicarePlus organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

''(A) the amount of the monthly premium for coverage for services under section 1852(a) under each MedicarePlus plan it offers under this part in each MedicarePlus payment area (as defined in section 1853(d)) in which the plan is being offered; and

''(B) the enrollment capacity in relation to the plan in each such area.

''(2) TERMINOLOGY.—In this part—

''(A) the term 'monthly premium' means, with respect to a MedicarePlus plan offered by a MedicarePlus organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

''(B) the term 'net monthly premium' means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

''(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a MedicarePlus organization for a MedicarePlus plan offered in a MedicarePlus payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

''(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a MedicarePlus organization under this part may not vary among individuals who reside in the same MedicarePlus payment area.

"(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

"(e) LIMITATION ON ENROLLEE COST-SHARING.—

"(1) FOR BASIC AND ADDITIONAL BENEFITS.—Except as provided in paragraph (2), in no event may—

"(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a MedicarePlus plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

"(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization for the year.

"(2) FOR SUPPLEMENTAL BENEFITS.—If the MedicarePlus organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

"(3) EXCEPTION FOR MSA PLANS.—Paragraphs (1) and (2) do not apply to an MSA plan.

"(4) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or

(2), the Secretary may determine such amount with respect to all individuals in the MedicarePlus payment area, the State, or in the United States, eligible to enroll in the MedicarePlus plan involved under this part or on the basis of other appropriate data.

''(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the 'excess amount', for an organization for a plan, is the amount (if any) by which—

''(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

''(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

''(D) NO APPLICATION TO MSA PLANS.—Subparagraph (A) shall not apply to an MSA plan.

"(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan in a MedicarePlus payment area.

"(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

"(2) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

"(3) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience (including no enrollment experience in the case of a provider-sponsored organization) to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

"(4) ADJUSTED COMMUNITY RATE.—

"(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'ad-

justed community rate' for a service or services means, at the election of a MedicarePlus organization, either—

"(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

"(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicarePlus coverage, or MedicarePlus eligible individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

"(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus plan of the organization may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

''(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans under this part. The Comptroller General shall monitoring auditing activities conducted under this subsection.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums on MedicarePlus plans or the offering of such plans.

''ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), a MedicarePlus organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus plan.

''(2) SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a MedicarePlus plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

''(i) the organization files an application for such waiver with the Secretary, and

''(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

''(B) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—A ground for approval of

such a waiver application is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of the application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

"(C) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—A ground for approval of such a waiver application is that the State has denied such a licensing application and—

"(i) the State has imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or

"(ii) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than requirements and standards relating to solvency) to such organizations that are not generally applicable to other entities engaged in substantially similar business.

"(D) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—A ground for approval of such a waiver application is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

"(i) such requirements are not the same as the solvency standards established under section 1856(a); or

"(ii) the State has imposed as a condition of approval of the license any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the re-

quirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this subparagraph, the term 'solvency requirements' means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

"(E) TREATMENT OF WAIVER.—Subject to section 1852(m), in the case of a waiver granted under this paragraph for a provider-sponsored organization—

"(i) the waiver shall be effective for a 36-month period, except it may be renewed based on a subsequent application filed during the last 6 months of such period,

"(ii) the waiver is conditioned upon the pendency of the licensure application during the period the waiver is in effect, and

"(iii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed. Nothing in clause (iii) shall be construed as waiving any provision of State law which relates to quality of care or consumer protection (and does not relate to solvency standards) and which is imposed on a uniform basis and is generally applicable to other entities engaged in substantially similar business.

"(F) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

"(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

"(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

"(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

"(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

"(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

"(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

"(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

"(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

"(1) IN GENERAL.—Each MedicarePlus organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

"(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

"(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

"(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

"(A) that is established or organized by a health care provider, or group of affiliated health care providers,

"(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

"(C) with respect to which those affiliated providers that share, directly or indirectly, substantial finan-

cial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

''(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(B), the Secretary—

''(A) shall take into account (i) the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and (ii) the practical difficulties in such an organization integrating a very wide range of service providers; and

''(B) may vary such proportion based upon relevant differences among organizations, such as their location in an urban or rural area.

''(3) AFFILIATION.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

''(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

''(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

''(C) both providers are part of an affiliated service group under section 414 of such Code.

''(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

''(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term 'health care provider' means—

''(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by

the State to engage in the delivery of such services in the State, and

"(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

"(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

"ESTABLISHMENT OF STANDARDS

"SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

"(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

"(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers, and

"(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.

"(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus organization's debts in the event of the organization's insolvency.

"(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

"(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

"(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

"(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

"(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

"(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

"(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and

whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target date of publication.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(b) ESTABLISHMENT OF OTHER STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part.

''(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of

such section. The Secretary shall also consider State model and other standards relating to consumer protection and assuring quality of care.

"(3) USE OF INTERIM STANDARDS.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

"(4) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

"(5) RELATION TO STATE LAWS.—Subject to section 1852(m), the standards established under this subsection shall supersede any State law or regulation with respect to MedicarePlus plans which are offered by MedicarePlus organizations under this part to the extent such law or regulation is inconsistent with such standards. The previous sentence shall not be construed as superseding a State law or regulation that is not related to solvency, that is applied on a uniform basis and is generally applicable to other entities engaged in substantially similar business, and that provides consumer protections in addition to, or more stringent than, those provided under the standards under this subsection.

''CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

''SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a MedicarePlus plan offered by a MedicarePlus organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than one MedicarePlus plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), the Secretary may not enter into a contract under this section with a MedicarePlus organization unless the organization has at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

''(2) EXCEPTION FOR MSA PLAN.—Paragraph (1) shall not apply with respect to a contract that relates only to an MSA plan.

''(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

"(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in an applicable paragraph of subsection (g)(3) on the MedicarePlus organization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

"(C) no longer substantially meets the applicable conditions of this part.

"(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1998 with respect to such coverage.

"(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

"(5) CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

"(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

"(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

"(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

"(B) shall have the right to audit and inspect any books and records of the MedicarePlus organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

"(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

"(3) DISCLOSURE.—

"(A) IN GENERAL.—Each MedicarePlus organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

"(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

"(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

"(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

"(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

"(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

"(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

"(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

"(i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a MedicarePlus organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

"(ii) any entity in which a person described in clause (i)—

"(I) is an officer or director;

"(II) is a partner (if such entity is organized as a partnership);

"(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

"(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

"(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

"(iv) any spouse, child, or parent of an individual described in clause (i).

"(C) ACCESS TO INFORMATION.—Each MedicarePlus organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

"(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

"(e) ADDITIONAL CONTRACT TERMS.—

"(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

"(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a MedicarePlus organization shall require the payment to the Secretary for the organization's pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemi-

nation of information) and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

"(3) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a contract with a MedicarePlus organization is terminated under this section, the organization shall notify each enrollee with the organization under this part of such termination.

"(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANIZATION.—

"(1) REQUIREMENT.—A contract under this part shall require a MedicarePlus organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

"(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a MedicarePlus eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

"(g) INTERMEDIATE SANCTIONS.—

"(1) IN GENERAL.—If the Secretary determines that a MedicarePlus organization with a contract under this section—

"(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(B) imposes net monthly premiums on individuals enrolled under this part in excess of the net monthly premiums permitted;

"(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

"(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

"(E) misrepresents or falsifies information that is furnished—

"(i) to the Secretary under this part, or

"(ii) to an individual or to any other entity under this part;

"(F) fails to comply with the requirements of section 1852(j)(3); or

"(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

"(2) REMEDIES.—The remedies described in this paragraph are—

"(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

"(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

"(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

"(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a MedicarePlus organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

"(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract

"(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of

procedures by the Secretary under subsection (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

"(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

"(h) PROCEDURES FOR TERMINATION.—

"(1) IN GENERAL.—The Secretary may terminate a contract with a MedicarePlus organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

"(B) the Secretary shall impose more severe sanctions on an organization that has a history of deficiencies or that has not taken steps to correct deficiencies the Secretary has brought to the organization's attention;

"(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

"(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

"(2) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of subsection (g) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

"(3) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

"DEFINITIONS; MISCELLANEOUS PROVISIONS

"SEC. 1859. (a) DEFINITIONS RELATING TO MEDICAREPLUS ORGANIZATIONS.—In this part—

"(1) MEDICAREPLUS ORGANIZATION.—The term 'MedicarePlus organization' means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

"(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' is defined in section 1855(e)(1).

"(b) DEFINITIONS RELATING TO MEDICAREPLUS PLANS.—

"(1) MEDICAREPLUS PLAN.—The term 'MedicarePlus plan' means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857.

"(2) MSA PLAN.—

"(A) IN GENERAL.—The term 'MSA plan' means a MedicarePlus plan that—

"(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

"(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as

deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

"(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

"(I) 100 percent of such expenses, or

"(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

"(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

"(i) for contract year 1999 shall be not more than $6,000; and

"(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita MedicarePlus growth percentage under section 1853(c)(6) for the year.

If the amount of the deductible under clause (ii) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

"(c) OTHER REFERENCES TO OTHER TERMS.—

"(1) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—The term 'MedicarePlus eligible individual' is defined in section 1851(a)(3).

"(2) MEDICAREPLUS PAYMENT AREA.—The term 'MedicarePlus payment area' is defined in section 1853(d).

"(3) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE.—The 'national per capita MedicarePlus growth percentage' is defined in section 1853(c)(6).

"(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms 'monthly premium' and 'net monthly premium' are defined in section 1854(a)(2).

"(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a MedicarePlus plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

"(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICAREPLUS PLANS.—

"(1) IN GENERAL.—In the case of a MedicarePlus religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

"(2) MEDICAREPLUS RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a MedicarePlus religious fraternal benefit society plan described in this paragraph is a MedicarePlus plan described in section 1851(a)(2)(A) that—

"(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

"(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assess-

ment features characteristic of fraternal insurance certificates.

"(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

"(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

"(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

"(C) offers, in addition to a MedicarePlus religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

"(D) does not impose any limitation on membership in the society based on any health status-related factor.

"(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a MedicarePlus religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.".

(b) REPORT ON COVERAGE OF BENEFICIARIES WITH END-STAGE RENAL DISEASE.—The Secretary of Health and Human Services shall provide for a study on the feasibility and impact of removing the limitation under section 1851(b)(3)(B) of the Social Security Act (as inserted by subsection (a)) on eligibility of most individuals medically determined to have end-stage renal disease to enroll in MedicarePlus plans. By not later than October 1, 1998, the Secretary shall submit to Con-

gress a report on such study and shall include in the report such recommendations regarding removing or restricting the limitation as may be appropriate.

(c) REPORT ON MEDICAREPLUS TEACHING PROGRAMS AND USE OF DSH AND TEACHING HOSPITALS.—Based on the information provided to the Secretary of Health and Human Services under section 1852(k) of the Social Security Act and such information as the Secretary may obtain, by not later than October 1, 1999, the Secretary shall submit to Congress a report on graduate medical education programs operated by MedicarePlus organizations and the extent to which MedicarePlus organizations are providing for payments to hospitals described in such section.

SEC. 4002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (2), by striking ''The Secretary'' and inserting ''Subject to paragraph (4), the Secretary'', and

(2) by adding at the end the following new paragraph:

''(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.''.

(b) TRANSITION.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) Except as provided in paragraph (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

''(A) the date standards for MedicarePlus organizations and plans are first established under section 1856 with respect to MedicarePlus organizations that are insurers or health maintenance organizations, or

''(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

"(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

"(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later then July 1, 1998.

"(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

"(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under subsection 1876(a), and

"(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this title attributable to such part) for the payment rates otherwise established under subsection (a).

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made under this section not in accordance with such rates.".

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1855(i),'' after ''1833(s),'', and

(B) by inserting '', MedicarePlus organization,'' after ''provider of services''; and

(2) in paragraph (2)(E), by inserting ''or a MedicarePlus organization'' after ''section 1833(a)(1)(A)''.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care'';

(3) by inserting ''with a MedicarePlus organization under part C or'' after ''any individual enrolled'';

(4) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''; and

(5) by inserting ''(less any payments under section 1858)'' after ''under this title''.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies

to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendments made by this chapter in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(i) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(e)(1) of such Act, as inserted by section 4001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

SEC. 4003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICAREPLUS CHANGES.—

(1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(A) in the matter before subclause (I), by inserting ''(including an individual electing a MedicarePlus plan under section 1851)'' after ''of this title''; and

(B) in subclause (II)—

(i) by inserting ''in the case of an individual not electing a MedicarePlus plan'' after ''(II)'', and

(ii) by inserting before the comma at the end the following: ''or in the case of an individual electing a MedicarePlus plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the MedicarePlus plan or under another medicare supplemental policy''.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting ''(including any MedicarePlus plan)'' after ''health insurance policies''.

(3) MEDICAREPLUS PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting ''or a MedicarePlus plan or'' after ''does not include''

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

''(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

''(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.''.

Subchapter B—Special Rules for MedicarePlus Medical Savings Accounts

SEC. 4006. MEDICAREPLUS MSA.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 138 as section 139 and by inserting after section 137 the following new section:

''SEC. 138. MEDICAREPLUS MSA.

''(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

''(b) MEDICAREPLUS MSA.—For purposes of this section, the term 'MedicarePlus MSA' means a medical savings account (as defined in section 220(d))—

''(1) which is designated as a MedicarePlus MSA,

"(2) with respect to which no contribution may be made other than—

"(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

"(B) a trustee-to-trustee transfer described in subsection (c)(4),

"(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

"(4) which is established in connection with an MSA plan described in section 1859(b)(2) of the Social Security Act.

"(c) SPECIAL RULES FOR DISTRIBUTIONS.—

"(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a MedicarePlus MSA—

"(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

"(B) section 220(d)(2)(C) shall not apply.

"(2) PENALTY FOR DISTRIBUTIONS FROM MEDICAREPLUS MSA NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a MedicarePlus MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

"(i) the amount of such payment or distribution, over

"(ii) the excess (if any) of—

"(I) the fair market value of the assets in such MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

"(II) an amount equal to 60 percent of the deductible under the MedicarePlus MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a MedicarePlus MSA.

"(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

"(i) becomes disabled within the meaning of section 72(m)(7), or

"(ii) dies.

"(C) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all MedicarePlus MSAs of the account holder shall be treated as 1 account,

"(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

"(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

"(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section

220(f)(8)(A) to an account which was a MedicarePlus MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such MedicarePlus MSA.

''(e) REPORTS.—In the case of a MedicarePlus MSA, the report under section 220(h)—

''(1) shall include the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

''(2) shall be furnished to the account holder—

''(A) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(B) in such manner as the Secretary prescribes in such regulations.

''(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a MedicarePlus MSA, and MedicarePlus MSA's shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.''

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting ''or section 138(c)(3)'' after ''section 220(f)(3)''.

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

''(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.''

(3) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

Subchapter C—GME, IME, and DSH Payments for Managed Care Enrollees

SEC. 4008. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION PAYMENTS FOR MANAGED CARE ENROLLEES.

(a) PAYMENTS TO MANAGED CARE ORGANIZATIONS OPERATING GRADUATE MEDICAL EDUCATION PROGRAMS.—Section 1853 (as inserted by section 4001) is amended by adding at the end the following:

"(h) PAYMENTS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION PROGRAMS.—

"(1) ADDITIONAL PAYMENT TO BE MADE.—Effective January 1, 1998, each contract with a MedicarePlus organization under this section (and each risk-sharing contract with an eligible organization under section 1876) shall provide for an additional payment for Medicare's share of allowable direct graduate medical education costs incurred by such an organization for an approved medical residency program.

"(2) ALLOWABLE COSTS.—If the organization has an approved medical residency program that incurs all or substantially all of the costs of the program, subject to section 1858(a)(3), the allowable costs for such a program shall equal the national average per resident amount times the number of full-time-equivalent residents in the program in non-hospital settings.

"(3) DEFINITIONS.—As used in this subsection:

"(A) The terms 'approved medical residency program', 'direct graduate medical education costs', and 'full-time-equivalent residents' have the same meanings as under section 1886(h).

"(B) The term 'Medicare's share' means, with respect to a MedicarePlus or eligible organization, the

ratio of the number of individuals enrolled with the organization under this part (or enrolled under a risk-sharing contract under section 1876, respectively) to the total number of individuals enrolled with the organization.

"(C) The term 'national average per resident amount' means an amount estimated by the Secretary to equal the weighted average amount that would be paid per full-time-equivalent resident under section 1886(h) for the calendar year (determined separately for primary care residency programs as defined under section 1886(h) (including obstetrics and gynecology residency programs) and for other residency programs).".

(b) PAYMENTS TO HOSPITALS FOR DIRECT AND INDIRECT COSTS OF GRADUATE MEDICAL EDUCATION PROGRAMS ATTRIBUTABLE TO MANAGED CARE ENROLLEES.—Part C of title XVIII, as amended by section 4001, is amended by inserting after section 1857 the following new section:

"PAYMENTS TO HOSPITALS FOR CERTAIN COSTS ATTRIBUTABLE TO MANAGED CARE ENROLLEES

"SEC. 1858. (a) COSTS OF GRADUATE MEDICAL EDUCATION.—

"(1) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each subsection (d) hospital (as defined in section 1886(d)(1)(B)), each PPS-exempt hospital described in clause (i) through (v) of such section, and for each hospital reimbursed under a reimbursement system authorized section 1814(b)(3) that—

"(A) furnishes services to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A and to individuals who are enrolled with a MedicarePlus organization under part C, and

"(B) has an approved medical residency training program.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to paragraph (3)(B), the amount of the payment under this subsection shall be the sum of—

"(i) the amount determined under subparagraph (B), and

"(ii) the amount determined under subparagraph (C).

Clause (ii) shall not apply in the case of a hospital that is not a PPS-exempt hospital described in clause (i) through (v) of section 1886(d)(1)(B),

"(B) DIRECT AMOUNT.—The amount determined under this subparagraph for a period is equal to the product of—

"(i) the aggregate approved amount (as defined in section 1886(h)(3)(B)) for that period; and

"(ii) the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to individuals described in paragraph (1).

"(C) INDIRECT AMOUNT.—The amount determined under this subparagraph is equal to the product of—

"(i) the amount of the indirect teaching adjustment factor applicable to the hospital under section 1886(d)(5)(B); and

"(ii) the product of—

"(I) the number of discharges attributable to individuals described in paragraph (1), and

"(II) the estimated average per discharge amount that would otherwise have been paid under section 1886(d)(1)(A) if the individuals had not been enrolled as described in such paragraph.

"(D) SPECIAL RULE.—The Secretary shall establish rules for the application of subparagraph (B) and for the computation of the amounts described in subparagraph (C)(i)) and subparagraph (C)(ii)(I) to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in a manner similar to the manner of applying such subparagraph and computing such amounts as if the hospital were not reimbursed under such section.

"(3) LIMITATION.—

"(A) DETERMINATIONS.—At the beginning of each year, the Secretary shall—

"(i) estimate the sum of the amount of the payments under this subsection and the payments under section 1853(h), for services or discharges occurring in the year, and

"(ii) determine the amount of the annual payment limit under subparagraph (C) for such year.

"(B) IMPOSITION OF LIMIT.—If the amount estimated under subparagraph (A)(i) for a year exceeds the amount determined under subparagraph (A)(ii) for the year, then the Secretary shall adjust the amounts of the payments described in subparagraph (A)(i) for the year in a pro rata manner so that the total of such payments in the year do not exceed the annual payment limit determined under subparagraph (A)(ii) for that year.

"(C) ANNUAL PAYMENT LIMIT.—

"(i) IN GENERAL.—The annual payment limit under this subparagraph for a year is the sum, over all counties or MedicarePlus payment areas, of the product of—

"(I) the annual GME per capita payment rate (described in clause (ii)) for the county or area, and

"(II) the Secretary's projection of average enrollment of individuals described in para-

graph (1) who are residents of that county or area, adjusted to reflect the relative demographic or risk characteristics of such enrollees.

"(ii) GME PER CAPITA PAYMENT RATE.—The GME per capita payment rate described in this clause for a particular county or MedicarePlus payment area for a year is the GME proportion (as specified in clause (iii)) of the annual MedicarePlus capitation rate (as calculated under section 1853(c)) for the county or area and year involved.

"(iii) GME PROPORTION.—For purposes of clause (ii), the GME proportion for a county or area and a year is equal to the phase-in percentage (specified in clause (vi)) of the ratio of (I) the projected GME payment amount for the county or area (as determined under clause (v)), to (II) the average per capita cost for the county or area for the year (determined under clause (vi)).

"(iv) PHASE-IN PERCENTAGE.—The phase-in percentage specified in this clause for—

"(I) 1998 is 20 percent,

"(II) 1999 is 40 percent,

"(III) 2000 is 60 percent,

"(IV) 2001 is 80 percent, or

"(V) any subsequent year is 100 percent.

"(v) PROJECTED GME PAYMENT AMOUNT.—he projected GME payment amount for a county or area—

"(I) for 1998, is the amount included in the per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the payment adjustments described in section 1886(d)(5)(B) and section 1886(h) for that county or area, adjusted by the general GME update factor (as defined in clause (vii)) for 1998, or

"(II) for a subsequent year, is the projected GME payment amount for the county or area for the previous year, adjusted by the general GME update factor for such subsequent year.

The Secretary shall determine the amount described in subclause (I) for a county or other area that includes hospitals reimbursed under section 1814(b)(3) as though such hospitals had not been reimbursed under such section.

"(vi) AVERAGE PER CAPITA COST.—The average per capita cost for the county or area determined under this clause for—

"(I) 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the county or area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in section 1853(c)(6), but determined without regard to the adjustment described in subparagraph (B) of such section); or

"(II) a subsequent year is the average per capita cost determined under this clause for the previous year increased by the national per capita MedicarePlus growth percentage for the year involved (as defined in section 1853(c)(6), but determined without regard to the adjustment described in subparagraph (B) of such section).

"(vii) GENERAL GME UPDATE FACTOR.—For purposes of clause (v), the 'general GME update factor' for a year is equal to the Secretary's estimate of the national average percentage change in average per capita payments under sections 1886(d)(5)(B) and 1886(h) from the previous year to the year involved. Such amount takes into account changes in law and regulation affecting payment amounts under such sections.".

SEC. 4009. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR MANAGED CARE ENROLLEES.

Section 1858, as inserted by section 4008(b), is further amended by adding at the end the following new subsection:

"(b) DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.—

"(1) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each subsection (d) hospital (as defined in section 1886(d)(1)(B)) and for each hospital reimbursed a demonstration project reimbursement system under section 1814(b)(3) that—

"(A) furnishes services to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A and to individuals who are enrolled with a MedicarePlus organization under this part, and

"(B) is (or, if it were not reimbursed under section 1814(b)(3), would qualify as) a disproportionate share hospital described in section 1886(d)(5)(F)(i).

"(2) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the amount of the payment under this subsection shall be the product of—

"(A) the amount of the disproportionate share adjustment percentage applicable to the hospital under section 1886(d)(5)(F); and

"(B) the product described in subsection (a)(2)(C)(ii).

The Secretary shall establish rules for the computation of the amount described in subparagraph (A) for a hospital reimbursed under section 1814(b)(3).

"(3) LIMIT.—

"(A) DETERMINATION.—At the beginning of each year, the Secretary shall—

"(i) estimate the sum of the payments under this subsection for services or discharges occurring in the year, and

"(ii) determine the amount of the annual payment limit under subparagraph (C)) for such year.

"(B) IMPOSITION OF LIMIT.—If the amount estimated under subparagraph (A)(i) for a year exceeds the amount determined under subparagraph (A)(ii) for the year, then the Secretary shall adjust the amounts of the payments under this subsection for the year in a pro rata manner so that the total of such payments in the year do not exceed the annual payment limit determined under subparagraph (A)(ii) for that year.

"(C) ANNUAL PAYMENT LIMIT.—The annual payment limit under this subparagraph for a year shall be determined in the same manner as the annual payment limit is determined under clause (i) of subsection (a)(3)(C), except that, for purposes of this clause, any reference in clauses (i) through (vii) of such subsection—

"(i) to a payment adjustment under subsection (a) is deemed a reference to a payment adjustment under this subsection, or

"(ii) to payments or payment adjustments under section 1886(d)(5)(B) and 1886(h) is deemed a reference to payments and payment adjustments under section 1886(d)(5)(F).".

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A—Programs of All-inclusive Care for the Elderly (PACE)

SEC. 4011. REFERENCE TO COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

For provision amending title XVIII of the Social Security Act to provide for payments to, and coverage of benefits under, Programs of All-inclusive Care for the Elderly (PACE), see section 3431.

SEC. 4012. REFERENCE TO ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

For provision amending title XIX of the Social Security Act to establish the PACE program as a medicaid State option, see section 3432.

Subchapter B—Social Health Maintenance Organizations

SEC. 4015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking ''1997'' and inserting ''2000'', and

(2) in paragraph (4), by striking ''1998'' and inserting ''2001''.

(b) EXPANSION OF CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''12,000'' and inserting ''36,000''.

(b) REPORT ON INTEGRATION AND TRANSITION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the MedicarePlus program under part C of title XVIII of the Social Security Act.

(2) PROVISION FOR TRANSITION.—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) PAYMENT POLICY.—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the

application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Other Programs

SEC. 4018. ORDERLY TRANSITION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of OBRA–1989 and section 13557 of OBRA–1993, is further amended—

(1) by inserting ''(a)'' before ''The Secretary'', and

(2) by adding at the end the following: ''Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals are enrolled with such projects before January 1, 1998.

''(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project enrollees to a non-demonstration project health care delivery system, such as through integration with private or public health plan, including a medicaid managed care or MedicarePlus plan.

''(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of this Act, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees may be minimized.''.

SEC. 4019. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required re-

lating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 4021. MEDICARE PAYMENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''MEDICARE PAYMENT ADVISORY COMMISSION

''SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review payment policies under this title, including the topics described in paragraph (2);

''(B) make recommendations to Congress concerning such payment policies; and

''(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies and an examination of issues affecting the medicare program.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—

''(A) MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C, the following:

''(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

''(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

''(iii) The implications of risk selection both among MedicarePlus organizations and between the

MedicarePlus option and the medicare fee-for-service option.

"(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations.

"(v) The impact of the MedicarePlus program on access to care for medicare beneficiaries.

"(vi) The appropriate role for the medicare program in addressing the needs of individuals with chronic illnesses.

"(vii) Other major issues in implementation and further development of the MedicarePlus program.

"(B) FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

"(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

"(ii) payment methodologies, and

"(iii) their relationship to access and quality of care for medicare beneficiaries.

"(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

"(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later

than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

"(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

"(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(6) APPROPRIATE COMMITTEES.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(c) MEMBERSHIP.—

"(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed by the Comptroller General.

"(2) QUALIFICATIONS.—

"(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different profes-

sionals, broad geographic representation, and a balance between urban and rural representatives.

"(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

"(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

"(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

"(3) TERMS.—

"(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

"(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

"(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Ex-

ecutive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

"(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

"(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

"(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the

Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(4) make advance, progress, and other payments which relate to the work of the Commission;

"(5) provide transportation and subsistence for persons serving without compensation; and

"(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(e) POWERS.—

"(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

"(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

"(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same

manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Advisory Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking subparagraph (B) of subsection (f)(1).

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Advisory Commission'' each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ''MedPAC'') by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 4031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following new paragraph:

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

''(ii) The individual is enrolled with a MedicarePlus organization under a MedicarePlus plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(e)(4).

''(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under

the same circumstances that would permit discontinuance of an individual's election of coverage under section 1851(e)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

''(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

''(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

''(II) the issuer of the policy substantially violated a material provision of the policy; or

''(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

''(v) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, with any MedicarePlus organization under a MedicarePlus plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 6 months (or 3 months for terminations occurring on or after January 1, 2003) of such enrollment.

''(vi) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, during or after the annual, coordinated election period under section 1851(e)(3)(B) occurring during 2002, with an organization or policy described in clause (v)(II), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the next annual, coordinated election period under such section.

''(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph has a benefit package classified as 'A', 'B', 'C', or 'F' under the standards established under subsection (p)(2).

''(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph also includes (if available from the same issuer) the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled.

''(iii) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (D)'', and

(2) by adding at the end the following new subparagraph:

''(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—

''(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

''(ii) of less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.''.

(c) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(d) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to

as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regu-

latory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4032. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT OF PROJECT.—The Secretary of Health and Human Services shall provide, beginning not later than 1 year after the date of the enactment of this Act, for implementation of a project (in this section referred to as the ''project'') to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of medicare benefits in a geographic area.

(b) RESEARCH DESIGN ADVISORY COMMITTEE.—

(1) IN GENERAL.—Before implementing the project under this section, the Secretary shall appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to make recommendations to the Secretary concerning the appropriate research design for implementing the project.

(2) INITIAL RECOMMENDATIONS.—The committee initially shall submit recommendations respecting the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and ac-

cess to care), information dissemination, and methods of evaluating the results of the project.

(3) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

(c) AREA SELECTION.—

(1) IN GENERAL.—Taking into account the recommendations of the advisory committee submitted under subsection (b), the Secretary shall designate areas in which the project will operate.

(2) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will actually be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors relating.

(d) MONITORING AND REPORT.—

(1) MONITORING IMPACT.—Taking into consideration the recommendations of the general advisory committee (appointed under subsection (b)), the Secretary shall closely monitor the impact of projects in areas on the price and quality of, and access to, medicare covered services, choice of health plan, changes in enrollment, and other relevant factors.

(2) REPORT.—The Secretary shall periodically report to Congress on the progress under the project under this section.

(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of section 1876 (and such requirements of part C of title XVIII, as amended by chapter 1), of the Social Security Act as may be necessary for the purposes of carrying out the project.

(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this section the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, MedicarePlus organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a) rather than on the bases described in section 1853 or 1876 of the Social Security Act.

Subtitle B—Prevention Initiatives

SEC. 4101. SCREENING MAMMOGRAPHY.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iii), to read as follows:

"(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed."; and

(2) by striking clauses (iv) and (v).

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking "and" before "(4)", and

(2) by inserting before the period at the end the following: ", and (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj))".

(c) CONFORMING AMENDMENT.—Section 1834(c)(1)(C) of such Act (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ", subject to the deductible established under section 1833(b),".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4102. SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(1) in the heading, by striking ''Smear'' and inserting ''Smear; Screening Pelvic Exam'';

(2) by inserting ''or vaginal'' after ''cervical'' each place it appears;

(3) by striking ''(nn)'' and inserting ''(nn)(1)'';

(4) by striking ''3 years'' and all that follows and inserting ''3 years, or during the preceding year in the case of a woman described in paragraph (3).''; and

(5) by adding at the end the following new paragraphs:

''(2) The term 'screening pelvic exam' means an pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

''(3) A woman described in this paragraph is a woman who—

''(A) is of childbearing age and has not had a test described in this subsection during each of the preceding 3 years that did not indicate the presence of cervical or vaginal cancer; or

''(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).''.

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 4101(b), is amended—

(1) by striking ''and'' before ''(5)'', and

(2) by inserting before the period at the end the following: '', and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn))''.

(c) CONFORMING AMENDMENTS.—Sections 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14), 1395y(a)(1)(F)) are each amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3)(42 U.S.C. 1395w–4(j)(3)) is amended by striking ''and (4)'' and inserting '', (4) and (14) (with respect to services described in section 1861(nn)(2))''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

(f) REPORT ON RESCREENING PAP SMEARS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the extent to which the use of supplemental computer-assisted diagnostic tests consisting of interactive automated computer-imaging of an exfoliative cytology test, in conjunction with the pap smears, improves the early detection of cervical or vaginal cancer and the costs implications for coverage of such supplemental tests under the medicare program.

SEC. 4103. PROSTATE CANCER SCREENING TESTS.

(a) COVERAGE.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraphs (N) and (O), and

(B) by inserting after subparagraph (O) the following new subparagraph:

''(P) prostate cancer screening tests (as defined in subsection (oo)); and''; and

(2) by adding at the end the following new subsection:

''Prostate Cancer Screening Tests

''(oo)(1) The term 'prostate cancer screening test' means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

''(2) The procedures described in this paragraph are as follows:

''(A) A digital rectal examination.

''(B) A prostate-specific antigen blood test.

''(C) For years beginning after 2001, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.''.

(b) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORATORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after ''laboratory tests'' the following: ''(including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests)''.

(c) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by striking ''and'' at the end,

(B) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

(C) by adding at the end the following new subparagraph:

''(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3)(42 U.S.C. 1395w–4(j)(3)), as amended by section 4102, is amended by inserting ''(2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo),'' after ''(2)(G)''

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4104. COVERAGE OF COLORECTAL SCREENING.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 4103(a), is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (P);

(ii) by adding ''and'' at the end of subparagraph (Q); and

(iii) by adding at the end the following new subparagraph:

''(R) colorectal cancer screening tests (as defined in subsection (pp)); and''; and

(B) by adding at the end the following new subsection:

''Colorectal Cancer Screening Tests

''(pp)(1) The term 'colorectal cancer screening test' means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

''(A) Screening fecal-occult blood test.

''(B) Screening flexible sigmoidoscopy.

''(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

''(D) Screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy under subparagraph (B) or screening colonoscopy under subparagraph (C).

''(E) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

"(2) In paragraph (1)(C), an 'individual at high risk for colorectal cancer' is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.".

(2) DEADLINE FOR DECISION ON COVERAGE OF SCREENING BARIUM ENEMA.—Not later than 2 years after the date of the enactment of this section, the Secretary of Health and Human Services shall issue and publish a determination on the treatment of screening barium enema as a colorectal cancer screening test under section 1861(pp) (as added by subparagraph (B)) as an alternative procedure to a screening flexible sigmoidoscopy or screening colonoscopy.

(b) FREQUENCY AND PAYMENT LIMITS.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

"(d) FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.—

"(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

"(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to colorectal cancer screening tests consisting of screening fecal-occult blood tests, except as provided by the Secretary under paragraph (4)(A), the payment amount established for tests performed—

"(i) in 1998 shall not exceed $5; and

"(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for colorectal cancer screening test consisting of a screening fecal-occult blood test—

"(i) if the individual is under 50 years of age; or

"(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

"(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services—

"(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic flexible sigmoidoscopy services; and

"(ii) that, in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part and that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

"(C) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

"(D) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

"(i) if the individual is under 50 years of age; or

"(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.

"(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

"(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)) that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) PAYMENT LIMIT.—In the case of screening colonoscopy services—

"(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic colonoscopy services; and

"(ii) that are performed in an ambulatory surgical center or hospital outpatient department, the

payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

''(C) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

''(D) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy.

''(4) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

''(A) REDUCTIONS IN PAYMENT LIMIT FOR SCREENING FECAL-OCCULT BLOOD TESTS.—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 2000, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

''(B) REVISION OF FREQUENCY.—

''(i) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and

such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests may be paid for under this subsection, but no such revision shall apply to tests performed before January 1, 2001.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy or a screening colonoscopy provided to an individual at high risk for colorectal cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

"(B) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(2) SPECIAL RULE FOR SCREENING BARIUM ENEMA.—If the Secretary of Health and Human Services issues a determination under subsection (a)(2) that screening barium enema should be covered as a colorectal cancer screening test under section 1861(pp) (as added by subsection (a)(1)(B)), the Secretary shall establish frequency limits (including revisions of frequency limits) for such procedure consistent with the frequency limits for other colorectal cancer screening tests under section 1834(d) (as added by subsection (b)(1)), and shall establish payment limits (including limits on charges of nonparticipating physicians) for such procedure consistent with the payment limits

under part B of title XVIII for diagnostic barium enema procedures.

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or section 1834(d)(1)'' after ''subsection (h)(1)''.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to paragraphs (1) and (4)(A) of section 1834(d), the Secretary''.

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by inserting after ''a service'' the following: ''(other than a colorectal cancer screening test consisting of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy)''.

(4) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 4103(c), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking ''and'' at the end,

(ii) in subparagraph (G), by striking the semicolon at the end and inserting '', and'', and

(iii) by adding at the end the following new subparagraph:

''(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''or (G)'' and inserting ''(G), or (H)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4105. DIABETES SCREENING TESTS.

(a) COVERAGE OF DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a) and 4104(a), is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (Q);

(ii) by adding ''and'' at the end of subparagraph (R); and

(iii) by adding at the end the following new subparagraph:

''(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and''; and

(B) by adding at the end the following new subsection:

''Diabetes Outpatient Self-Management Training Services

''(qq)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician

or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3)(42 U.S.C. 1395w–4(j)(3)) as amended in sections 4102 and 4103, is amended by inserting ''(2)(S),'' before ''(3),''.

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the pe-

riod the following: ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4106. STANDARDIZATION OF MEDICARE COVERAGE OF BONE MASS MEASUREMENTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a), 4104(a), 4105(a), is amended—

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking ''and'' at the end,

(B) by striking the period at the end of paragraph (14) and inserting ''; and'',

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively, and

(D) by inserting after paragraph (14) the following new paragraph:

"(15) bone mass measurement (as defined in subsection (rr)).''; and

(2) by inserting after subsection (qq) the following new subsection:

"Bone Mass Measurement

"(rr)(1) The term 'bone mass measurement' means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

"(2) For purposes of this subsection, the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

"(A) an estrogen-deficient woman at clinical risk for osteoporosis;

"(B) an individual with vertebral abnormalities;

"(C) an individual receiving long-term glucocorticoid steroid therapy;

"(D) an individual with primary hyperparathyroidism; or

"(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

"(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.''.

(b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by sections 4102, 4103, and 4105, is amended—

(1) by striking "(4) and (14)'' and inserting "(4), (14)'' and

(2) by inserting " and (15)'' after "1861(nn)(2))''.

(c) CONFORMING AMENDMENTS.—Sections 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a),

1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking ''paragraphs (15) and (16)'' each place it appears and inserting ''paragraphs (16) and (17)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after July 1, 1998.

SEC. 4107. VACCINES OUTREACH EXPANSION.

(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

(b) APPROPRIATION.—There are hereby appropriated for each of fiscal years 1998 through 2002, $8,000,000 to the Campaign described in subsection (a). Of the amount of such appropriation in each fiscal year, 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 4108. STUDY ON PREVENTIVE BENEFITS.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act. The analysis shall consider both the short term and long term benefits, and costs to the medicare program, of such expansion or modification,

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means

and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to coverage of the following preventive benefits:

(A) Nutrition therapy, including parenteral and enteral nutrition.

(B) Skin cancer screening.

(C) Medically necessary dental care.

(D) Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.

(E) Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

Subtitle C—Rural Initiatives

SEC. 4206. INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—

(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas.

(B) MEDICALLY UNDERSERVED DEFINED.—As used in this paragraph, the term ''medically underserved'' has the meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

(3) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (d).

(4) DURATION OF PROJECT.—The project shall be conducted over a 4-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the project include the following:

(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient quality-of-life and reduce overall health care costs.

(2) Developing a curriculum to train, and providing standards for credentialing and licensure of, health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient's home, remote monitoring of a patient's medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

(4) Application of medical informatics to residents with limited English language skills.

(5) Developing standards in the application of telemedicine and medical informatics.

(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term

''eligible health care provider telemedicine network'' means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

(1) The consortium is located in an area with one of the highest concentrations of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities, universities, and telecommunications providers, in order to conduct the project.

(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project and the source and amount of non-Federal funds used in the project.

(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act.

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subpara-

graph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

(iv) Payments to practitioners and providers under the medicare programs.

(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

(3) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $30,000,000.

(4) LIMITATION ON COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project in excess of 20 percent

of the recognized costs of the project attributable to such services.

(e) REPORTS.—The Secretary shall submit to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evaluation of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

(f) DEFINITIONS.—For purposes of this section:

(1) INTERVENTIONAL INFORMATICS.—The term ''interventional informatics'' means using information technology and virtual reality technology to intervene in patient care.

(2) MEDICAL INFORMATICS.—The term ''medical informatics'' means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

(3) PROJECT.—The term ''project'' means the demonstration project under this section.

Subtitle D—Anti-Fraud and Abuse Provisions

SEC. 4301. PERMANENT EXCLUSION FOR THOSE CONVICTED OF 3 HEALTH CARE RELATED CRIMES.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended—

(1) in subparagraph (A), by inserting ''or in the case described in subparagraph (G)'' after ''subsection (b)(12)'';

(2) in subparagraphs (B) and (D), by striking ''In the case'' and inserting ''Subject to subparagraph (G), in the case''; and

(3) by adding at the end the following new subparagraph:

''(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date and before the date of the conviction for which the exclusion is imposed) been convicted—

''(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

''(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.''.

SEC. 4302. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

(1) by striking ''or'' at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting '', or''; and

(3) by adding after subparagraph (C) the following new subparagraph:

''(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(b) MEDICARE PART B.—Section 1842 (42 U.S.C. 1395u) is amended by adding after subsection (r) the following new subsection:

''(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h) or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines

is inconsistent with the best interests of program beneficiaries.''.

(c) MEDICAID.—Section 1902(a)(23) (42 U.S.C. 1396(a)) is amended—

(1) by relocating the matter that precedes ''provide that, (A)'' immediately before the semicolon;

(2) by inserting a semicolon after ''1915'';

(3) by striking the comma after ''Guam'' and inserting a semicolon; and

(4) by inserting before the semicolon at the end the following: ''and except that this provision does not require a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 4303. INCLUSION OF TOLL-FREE NUMBER TO REPORT MEDICARE WASTE, FRAUD, AND ABUSE IN EXPLANATION OF BENEFITS FORMS.

(a) IN GENERAL.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(1) by striking ''and'' at the end of subparagraph (D),

(2) by striking the period at the end of subparagraph (E), and

(3) by adding at the end the following new subparagraph:

''(E) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to explanations of benefits provided on

or after such date (not later than January 1, 1999) as the Secretary of Health and Human Services shall provide.

SEC. 4304. LIABILITY OF MEDICARE CARRIERS AND FISCAL INTERMEDIARIES FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

(a) REIMBURSEMENT TO THE SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.—

(1) REQUIREMENTS FOR FISCAL INTERMEDIARIES.—

(A) IN GENERAL.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(m) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid by the agency or organization for a service under this title which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.''.

(B) CONFORMING AMENDMENT.—Subsection (i) of such section is amended by adding at the end the following new paragraph:

''(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (m).''.

(2) REQUIREMENTS FOR CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (I); and

(B) by inserting after subparagraph (I) the following new subparagraph:

''(J) will reimburse the Secretary for any amounts paid by the carrier for an item or service under this part which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156,

from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion, and''.

(3) MEDICAID PROVISION.—Section 1902(a)(39) (42 U.S.C. 1396a(a)(39)) is amended by inserting before the semicolon at the end the following: '', and provide further for reimbursement to the Secretary of any payments made under the plan or any item or service furnished, directed, or prescribed by the excluded individual or entity during such period, after the Secretary notifies the State of such exclusion''.

(b) CONFORMING REPEAL OF MANDATORY PAYMENT RULE.—Paragraph (2) of section 1862(e) (42 U.S.C. 1395y(e)) is amended to read as follows:

''(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence.''.

(c) EFFECTIVE DATES.—The amendments made by this section shall apply to contracts and agreements entered into, renewed, or extended after the date of the enactment of this Act, but only with respect to claims submitted on or after the later of January 1, 1998, or the date such entry, renewal, or extension becomes effective.

SEC. 4305. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

(A) by striking ''or'' at the end of clause (i), and

(B) by striking the dash at the end of clause (ii) and inserting ''; or'', and

(C) by inserting after clause (ii) the following:

''(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership

or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—''; and

(2) by adding after subsection (i) the following new subsection:

''(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

''(1) The term 'immediate family member' means, with respect to a person—

''(A) the husband or wife of the person;

''(B) the natural or adoptive parent, child, or sibling of the person;

''(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

''(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

''(E) the grandparent or grandchild of the person; and

''(F) the spouse of a grandparent or grandchild of the person.

''(2) The term 'member of the household' means, with respect to an person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 4306. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by adding ''or'' at the end of paragraph (5); and

(3) by adding after paragraph (5) the following new paragraph:

''(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;''.

(b) EFFECTIVE DATES.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

SEC. 4307. DISCLOSURE OF INFORMATION AND SURETY BONDS.

(a) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis with—

''(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest, and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

''(B) a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1861(o) (42 U.S.C. 1395x(o)) is amended—

(A) in paragraph (7), by inserting ''and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'' after ''financial security of the program'', and

(B) by adding at the end the following: ''The Secretary may waive the requirement of a bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''.

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking ''the financial security requirement'' and inserting ''the financial security and surety bond requirements''; and

(B) in clause (ii), by striking ''the financial security requirement described in subsection (o)(7) applies'' and inserting ''the financial security and surety bond requirements described in subsection (o)(7) apply''.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For provision of current law requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act.

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following: ''The Secretary, in the Secretary's

discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians' services) under this part.''.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: ''and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000'', and

(2) by adding after and below subparagraph (I) the following:

''The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.''.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after ''as the Secretary may find necessary,'' the following: ''and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000'', and

(2) by adding at the end the following: ''The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''.

(f) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after such date. The Secretary of Health and Human Serv-

ices shall modify participation agreements under section 1866(a)(1) of the Social Security Act with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 4308. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: ''and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest. Use of the social security account number under this section shall be limited to identity verification and identity matching purposes only. The social security account number shall not be disclosed to any person or entity other than the Secretary, the Social Security Administration, or the Secretary of the Treasury, In obtaining the social security account numbers of the disclosing entity and other persons described in this section, the Secretary shall comply with section 7 of the Privacy Act of 1974 (5 U.S.C. 552a note)''.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (1);

(B) by striking the period at the end of paragraph

(2) and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).''; and

(2) in subsection (c) by inserting ''(or, for purposes of subsection (a)(3), any entity receiving payment)'' after ''on an assignment-related basis''.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

''(c) VERIFICATION.—

''(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

''(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

''(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

''(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

"(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.".

(d) REPORT.—Before this subsection shall be effective, the Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under the amendments made by this section. If Congress determines that the Secretary has not taken adequate steps to assure the confidentiality of social security account numbers to be provided to the Secretary under the amendments made by this section, the amendments made by this section shall not take effect.

(e) EFFECTIVE DATES.—Subject to subsection (d)—

(1) the amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d); and

(2) the amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 4309. ADVISORY OPINIONS REGARDING CERTAIN PHYSICIAN SELF-REFERRAL PROVISIONS.

Section 1877(g) (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

"(6) ADVISORY OPINIONS.—

"(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section.

"(B) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Sec-

retary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(C) APPLICATION OF CERTAIN PROCEDURES.—The Secretary shall, to the extent practicable, apply the regulations promulgated under section 1128D(b)(5) to the issuance of advisory opinions under this paragraph.

''(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made during the period described in section 1128D(b)(6).''.

SEC. 4310. NONDISCRIMINATION IN POST-HOSPITAL REFERRAL TO HOME HEALTH AGENCIES.

(a) NOTIFICATION OF AVAILABILITY OF HOME HEALTH AGENCIES AS PART OF DISCHARGE PLANNING PROCESS.—Section 1861(ee)(2) (42 U.S.C. 1395x(ee)(2)) is amended—

(1) in subparagraph (D), by inserting before the period the following: '', including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available''; and

(2) by adding at the end the following:

''(H) Consistent with section 1802, the discharge plan shall—

''(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

''(ii) identify (in a form and manner specified by the Secretary) any home health agency (to whom the individual is referred) in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(R)) or which has such an interest in the hospital.''.

(b) MAINTENANCE AND DISCLOSURE OF INFORMATION ON POST-HOSPITAL HOME HEALTH AGENCIES.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (Q),

(2) by striking the period at the end of subparagraph (R), and

(3) by adding at the end the following:

''(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in a home health agency, or in which such an agency has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an agency, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

''(i) the nature of such financial interest,

''(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

''(iii) the percentage of such individuals who received such services from such provider (or another such provider).''.

(c) DISCLOSURE OF INFORMATION TO THE PUBLIC.—Title XI is amended by inserting after section 1145 the following new section:

''PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL FINANCIAL INTEREST AND REFERRAL PATTERNS

''SEC. 1146. The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(R).''.

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to discharges occurring on or after 90 days after the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall issue regulations by not later than 1 year after the date of the enactment of this Act to carry out the amendments made by subsections (b) and (c) and such amendments shall take effect as of such date (on or after the issuance

of such regulations) as the Secretary specifies in such regulations.

SEC. 4311. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''1128B(b)'' and inserting ''1128A(b)''.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking ''Veterans' Administration'' and inserting ''Department of Veterans Affairs''.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''paragraph (4)'' and inserting ''paragraphs (1) through (4)''.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking ''any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))'' and inserting ''any Federal health care program (as defined in section 1128B(f))''; and

(2) in subsection (b), by striking ''any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program'' and inserting ''any Federal health care program (as defined in section 1128B(f))''.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

''(6) SANCTIONS FOR FAILURE TO REPORT.—

''(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to

be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.''.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 2—PAYMENT UNDER PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 4411. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking ''of 80 percent'', and

(2) by inserting before the period at the end the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

SEC. 4412. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

SEC. 4413. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) IN GENERAL.—With respect to hospital outpatient services designated by the Secretary (in this section referred to as 'covered OPD services') and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

''(2) SYSTEM REQUIREMENTS.—Under the payment system—

"(A) the Secretary shall develop a classification system for covered OPD services;

"(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

"(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

"(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

"(E) the Secretary shall establish other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments, adjustments to account for variations in coinsurance payments for procedures with similar resource costs, or adjustments for certain classes of hospitals; and

"(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

"(3) CALCULATION OF BASE AMOUNTS.—

"(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under

section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

"(B) UNADJUSTED COPAYMENT AMOUNT.—

"(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

"(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

"(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

"(C) CALCULATION OF CONVERSION FACTORS.—

"(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in a manner such that the sum for all services and groups of the products (described in subclause (II) for each such service or group)

equals the total projected amount described in subparagraph (A).

"(II) PRODUCT DESCRIBED.—The product described in this subclause, for a service or group, is the product of the medicare pre-deductible OPD fee payment amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

"(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

"(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD payment increase factor' for services furnished in a year is equal to the sum of—

"(I) market basket percentage increase (applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, and

"(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points, but in no case greater than such number of percentage points as will result in the pre-deductible payment percentage exceeding 80 percent.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under sub-

clause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

''(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

''(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

''(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

''(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

''(i) the conversion factor computed under subparagraph (C) for the year, and

''(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

''(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

''(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

"(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted sum by the amount of the deductible under section 1833(b), to the extent applicable.

"(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount so determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

"(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

"(5) COPAYMENT AMOUNT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

"(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

"(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

"(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph

(A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

''(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

''(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

''(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appro-

priately adjust the update to the conversion factor otherwise applicable in a subsequent year.

''(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

''(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

''(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

''(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

''(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

''(B) the calculation of base amounts under paragraph (3);

''(C) periodic adjustments made under paragraph (6); and

''(D) the establishment of a separate conversion factor under paragraph (8)(B).''.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the rea-

sonable charge, the applicable copayment amount established under section 1833(t)(5).''.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking ''or'' at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting ''; or'', and

(3) by adding at the end the following new subparagraph:

''(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).''.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 13951(i)(3)(A)) is amended—

(I) by inserting ''before January 1, 1999,'' after ''furnished'', and

(II) by striking ''in a cost reporting period''.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 13951(a)(4)) is amended by inserting ''or subsection (t)'' before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 1999,'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ''or, for services or procedures performed on or after January 1, 1999, (t)'' before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''furnished before January 1, 1999,'' after ''(i)'',

(B) in clause (ii), by inserting ''before January 1, 1999,'' after ''furnished'',

(C) by redesignating clause (iii) as clause (iv),and

(D) by inserting after clause (ii), the following new clause:

''(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or''.

Subchapter B—Rehabilitation Services

SEC. 4421. REHABILITATION AGENCIES AND SERVICES.

(a) PAYMENT BASED ON FEE SCHEDULE.—

(1) SPECIAL PAYMENT RULES.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2) in the matter before subparagraph (A), by inserting ''(C),'' before ''(D)'';

(B) in paragraph (6), by striking ''and'' at the end;

(C) in paragraph (7), by striking the period at the end and inserting ''; and'';

(D) by adding at the end the following new paragraph:

''(8) in the case of services described in section 1832(a)(2)(C) (that are not described in section 1832(a)(2)(B)), the amounts described in section 1834(k).''.

(2) PAYMENT RATES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES.—

''(1) IN GENERAL.—With respect to outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational ther-

apy services for which payment is determined under this subsection, the payment basis shall be—

"(A) for services furnished during 1998, the amount determined under paragraph (2); or

"(B) for services furnished during a subsequent year, 80 percent of the lesser of—

"(i) the actual charge for the services, or

"(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

"(2) PAYMENT IN 1998 BASED UPON CHARGES OR ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

"(A) the charges imposed for the services, or

"(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

"(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this paragraph, the term 'applicable fee schedule amount' means, with respect to services furnished in a year, the fee schedule amount established under section 1848 for such services furnished during the year or, if there is no such fee schedule amount established for such services, for such comparable services as the Secretary specifies.

"(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term 'adjusted reasonable costs' means reasonable costs determined reduced by—

"(A) 5.8 percent of the reasonable costs for operating costs, and

"(B) 10 percent of the reasonable costs for capital costs.

"(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).''.

(b) APPLICATION OF STANDARDS TO OUTPATIENT OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PROVIDED AS AN INCIDENT TO A PHYSICIAN'S PROFESSIONAL SERVICES.—Section 1862(a), as amended by section 4401(b), (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (16);

(2) by striking the period at the end of paragraph (17) and inserting ''; or''; and

(3) by inserting after paragraph (17) the following:

''(18) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions under the second sentence of section 1861(g) or 1861(p) as such standards and conditions would apply to such therapy services if furnished by a therapist.''.

(c) APPLYING FINANCIAL LIMITATION TO ALL REHABILITATION SERVICES.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended—

(1) in the first sentence, by striking ''services described in the second sentence of section 1861(p)'' and inserting ''physical therapy services of the type described in section 1861(p) (regardless of who furnishes the services or whether the services may be covered as physicians' services so long as the services are furnished other than in a hospital setting)'', and

(2) in the second sentence, by striking ''outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g)'' and inserting ''occupational therapy serv-

ices (of the type that are described in section 1861(p) through the operation of section 1861(g)), regardless of who furnishes the services or whether the services may be covered as physicians' services so long as the services are furnished other than in a hospital setting''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998; except that the amendments made by subsection (c) apply to services furnished on or after January 1, 1999.

SEC. 4422. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF).

(a) PAYMENT BASED ON FEE SCHEDULE.—

(1) SPECIAL PAYMENT RULES.—Section 1833(a) (42 U.S.C. 1395l(a)), as amended by section 4421(a), is amended—

(A) in paragraph (3), by striking ''subparagraphs (D) and (E) of section 1832(a)(2)'' and inserting ''section 1832(a)(2)(E)'';

(B) in paragraph (7), by striking ''and'' at the end;

(C) in paragraph (8), by striking the period at the end and inserting ''; and'';

(D) by adding at the end the following new paragraph:

''(9) in the case of services described in section 1832(a)(2)(E), the amounts described in section 1834(k).''.

(2) PAYMENT RATES.—Section 1834(k) (42 U.S.C. 1395m(k)), as added by section 4421(a), is amended—

(A) in the heading, by inserting ''AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES'' after ''THERAPY SERVICES''; and

(B) in paragraph (1), by inserting ''and with respect to comprehensive outpatient rehabilitation facility services'' after ''occupational therapy services''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January

1, 1998, and to portions of cost reporting periods occurring on or after such date.

Subchapter C—Ambulance Services

SEC. 4431. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year after application of this subparagraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.".

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year after the application of this subparagraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.".

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 4619(b)(1), is amended—

(A) by striking ''and (P)'' and inserting ''(P)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l);''.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m), as amended by section 4421(a)(2), is amended by adding at the end the following new subsection:

''(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

''(2) CONSIDERATIONS.—In establishing such fee schedule the Secretary shall—

''(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

''(B) establish definitions for ambulance services which link payments to the type of services provided;

''(C) consider appropriate regional and operational differences;

''(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

''(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

''(3) SAVINGS.—In establishing such fee schedule the Secretary shall—

"(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4431 of the Balanced Budget Act of 1997 had not been made; and

"(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

"(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).".

(3) EFFECTIVE DATE.—The amendments made by this section apply to ambulance services furnished on or after January 1, 2000.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgat-

ing regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as ''ALS intercept services'') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

SEC. 4432. DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT.

(a) DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.—The Secretary of Health and Human Services shall establish up to 3 demonstration projects under which, at the request of a county or parish, the Secretary enters into a contract with the county or parish under which—

(1) the county or parish furnishes (or arranges for the furnishing) of ambulance services for which payment may be made under part B of title XVIII of the Social Security

Act for individuals residing in the county or parish who are enrolled under such part, except that the county or parish may not enter into the contract unless the contract covers at least 80 percent of the individuals residing in the county or parish who are enrolled under such part;

(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the county or parish in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each.

(b) AMOUNT OF PAYMENT.—

(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a county or parish under a demonstration project contract under subsection (a) shall be equal to the product of—

(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

(B) 1/12 of the capitated payment rate for the year established under paragraph (2).

(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the ''capitated payment rate'' applicable to a contract under this subsection for a calendar year is equal to 95 percent of—

(A) for the first calendar year for which the contract is in effect, the average annual per capita payment made under part B of title XVIII of the Social Security Act with respect to ambulance services furnished to such individuals during the 3 most recent calendar years for which data on the amount of such payment is available; and

(B) for a subsequent year, the amount provided under this paragraph for the previous year increased by the percentage increase in the consumer price index for

all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(c) OTHER TERMS OF CONTRACT.—The Secretary and the county or parish may include in a contract under this section such other terms as the parties consider appropriate, including—

(1) covering individuals residing in additional counties or parishes (under arrangements entered into between such counties or parishes and the county or parish involved);

(2) permitting the county or parish to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

(3) implementing such other innovations as the county or parish may propose to improve the quality of ambulance services and control the costs of such services.

(d) CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.—Payments under a contract to a county or parish under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act for the services covered under the contract which are furnished to individuals who reside in the county or parish.

(e) REPORT ON EFFECTS OF CAPITATED CONTRACTS.—

(1) STUDY.—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

(2) REPORT.—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects.

CHAPTER 3—PAYMENT UNDER PARTS A AND B

SEC. 4441. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 4011, is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

''(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of the this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

''(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

"(3) PAYMENT BASIS.—

"(A) INITIAL BASIS.—

"(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

"(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

"(B) ANNUAL UPDATE.—

"(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

"(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket per-

centage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

''(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

''(4) PAYMENT COMPUTATION.—

''(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

''(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

''(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

''(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate

case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

"(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

"(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

"(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

"(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

"(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

"(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the

length of time of the service visit, as measured in 15 minute increments.

''(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(1) the establishment of a transition period under subsection (b)(1);

''(2) the definition and application of payment units under subsection (b)(2);

''(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

''(4) the adjustment for outliers under subsection (b)(3)(C);

''(5) case mix and area wage adjustments under subsection (b)(4);

''(6) any adjustments for outliers under subsection (b)(5); and

''(7) the amounts or types of exceptions or adjustments under subsection (b)(7).''.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''and 1886'' and inserting ''1886, and 1895''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;'';

(ii) by striking ''and'' at the end of subparagraph (E);

(iii) by adding ''and'' at the end of subparagraph (F); and

(iv) by adding at the end the following new subparagraph:

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 4401(b)(2), is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home

health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 4401(b), is amended by striking ''and section 1842(b)(6)(E)'' and inserting '', section 1842(b)(6)(E), and section 1842(b)(6)(F)''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4401(b) and 4421(b), is amended—

(i) by striking ''or'' at the end of paragraph (17);

(ii) by striking the period at the end of paragraph (18) and inserting ''; or''; and

(iii) inserting after paragraph (18) the following new paragraph:

''(19) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PHYSICIANS' SERVICES

SEC. 4601. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

"(C) SPECIAL RULES FOR 1998.—The single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle G of title X of the Balanced Budget Act of 1997.".

(b) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(1) by striking "(or factors)" each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as redesignated by subsection (a)(1)),

(2) in subsection (d)(1)(A), by striking "or updates",

(3) in subsection (d)(1)(D) (as redesignated by subsection (a)(1)), by striking "(or updates)" each place it appears, and

(4) in subsection (i)(1)(C), by striking "conversion factors" and inserting "the conversion factor".

SEC. 4602. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

"(3) UPDATE.—

"(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

"(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

"(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal to the quotient (as estimated by the Secretary) of—

"(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) during the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the sum of the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

"(ii) the actual expenditures for physicians' services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

"(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

"(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

"(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under sub-

paragraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

"(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) - 1; or

"(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) -1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the update for years beginning with 1999.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

SEC. 4603. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

"(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

"(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

"(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than MedicarePlus plan enrollees) from the previous fiscal year to the fiscal year involved,

"(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

"(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

"(3) DEFINITIONS.—In this subsection:

"(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a MedicarePlus plan enrollee.

"(B) MEDICAREPLUS PLAN ENROLLEE.—The term 'MedicarePlus plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.".

(b) CONFORMING AMENDMENTS.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(1) in the heading, by striking "VOLUME PERFORMANCE STANDARD RATES OF INCREASE" and inserting "SUSTAINABLE GROWTH RATE"; and

(2) in paragraph (1)—

(A) in the heading, by striking "VOLUME PERFORMANCE STANDARD RATES OF INCREASE" and inserting "SUSTAINABLE GROWTH RATE",

(B) by striking subparagraphs (A) and (B); and

(C) in paragraph (1)(C)—

(i) in the heading, by striking ''PERFORMANCE STANDARD RATES OF INCREASE'' and inserting ''SUSTAINABLE GROWTH RATE'';

(ii) in the first sentence, by striking ''with 1991), the performance standard rates of increase'' and all that follows through the first period and inserting ''with 1999), the sustainable growth rate for the fiscal year beginning in that year.''; and

(iii) in the second sentence, by striking ''January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990'' and inserting ''January 1, 1999, the sustainable growth rate for fiscal year 1999''.

SEC. 4604. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 4601, is amended—

(A) in subparagraph (C), striking ''The single'' and inserting ''Except as provided in subparagraph (D), the single'';

(B) by redesignating subparagraph (D) as subparagraph (E); and

(C) by inserting after subparagraph (C) the following new subparagraph:

''(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units. ''.

(b) CLASSIFICATION OF ANESTHESIA SERVICES.—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w–4(j)(1)) is amended—

(1) by striking ''and including anesthesia services''; and

(2) by inserting before the period the following: ''(including anesthesia services)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 4605. IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE.

(a) 1-YEAR DELAY IN IMPLEMENTATION.—Section 1848(c) (42 U.S.C. 1395w–4(c)) is amended—

(1) in paragraph (2)(C)(ii), in the matter before subclause (I) and after subclause (II), by striking ''1998'' and inserting ''1999'' each place it appears; and

(2) in paragraph (3)(C)(ii), by striking ''1998'' and inserting ''1999''.

(b) PHASED-IN IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w–4(c)(2)(C)(ii)) is further amended—

(A) by striking the comma at the end of clause (ii) and inserting a period and the following:

''For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.''.

(2) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w–4(c)(3)(C)(ii)), as amended by subsection (a)(2), is amended by striking ''1999'' and inserting ''2002''.

(c) REQUIREMENTS FOR DEVELOPING NEW RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—

(1) DEVELOPMENT.—For purposes of section 1848(c)(2)(C) of the Social Security Act, the Secretary of Health and Human Services shall develop new resource-based relative value units. In developing such units the Secretary shall—

(A) utilize, to the maximum extent practicable, generally accepted accounting principles and standards which (i) recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures, and (ii) use actual data on equipment utilization and other key assumptions, such as the proportion of costs which are direct versus indirect;

(B) study whether hospital cost reduction efforts and changing practice patterns may have increased physician practice costs under part B of the medicare program;

(C) consider potential adverse effects on patient access under the medicare program; and

(D) consult with organizations representing physicians regarding methodology and data to be used, including data for impact projections, in order to ensure that sufficient input has been received by the affected physician community.

(2) REPORT.—The Secretary shall transmit a report by March 1, 1998, on the development of resource-based relative value units under paragraph (1) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data to be used in developing the value units and an explanation of the methodology.

(3) NOTICE OF PROPOSED RULEMAKING.—The Secretary shall publish a notice of proposed rulemaking with the new resource-based relative value units on or before

May 1, 1998, and shall allow for a 90-day public comment period.

(4) ITEMS INCLUDED.—The proposed new rule shall include the following:

(A) Detailed impact projections which compare new proposed payment amounts on data on actual physician practice expenses.

(B) Impact projections for specialties and subspecialties, geographic payment localities, urban versus rural localities, and academic versus nonacademic medical staffs.

(C) Impact projections on access to care for medicare patients and physician employment of clinical and administrative staff.

SEC. 4606. DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS' SERVICES.

(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

(A) the hospital-specific per discharge relative value under subsection (b); and

(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

(2) NOTICE TO MEDICAL STAFFS AND CARRIERS.—The Secretary shall notify the medical executive committee of each hospital identifies under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1).

(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year, shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under paragraph (3)).

(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional pay-

ments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act. The adjustment for teaching status or disproportionate share shall not be less than zero.

(c) DEFINITIONS.—For purposes of this section:

(1) HOSPITAL.—The term ''hospital'' means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) .

(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

(iii) under the clinical privileges, the individual may provide physicians'' services independently within the scope of the individual's clinical privileges, or

(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

(3) PHYSICIANS' SERVICES.—The term ''physicians'' services'' means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)).

(4) RURAL AREA; URBAN AREA.—The terms ''rural area'' and ''urban area'' have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services .

(6) TEACHING HOSPITAL.—The term ''teaching hospital'' means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).

SEC. 4607. NO X-RAY REQUIRED FOR CHIROPRACTIC SERVICES.

(a) IN GENERAL.—Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking ''demonstrated by X-ray to exist''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after January 1, 1998.

(c) UTILIZATION GUIDELINES.—The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of chiropractic services under part B of title XVIII of the Social Security Act in cases in which a subluxation has not been demonstrated by X-ray to exist.

SEC. 4608. TEMPORARY COVERAGE RESTORATION FOR PORTABLE ELECTROCARDIOGRAM TRANSPORTATION.

(a) IN GENERAL.—Effective for electrocardiogram tests performed during 1998, the Secretary of Health and Human Services shall restore separate payment, under part B of title XVIII of the Social Security Act, for the transportation of electrocardiogram equipment (HCPCS code R0076) based upon the status code and relative value units established for such service as of December 31, 1996.

(b) REPORT.—By not later than July 1, 1998, the Comptroller General shall submit to Congress a report on the appropriateness of continuing such payment.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 4611. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, 1995, 1996, and 1997'', and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

''(C) for each of the years 1998 through 2002, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking '', and'' at the end of clause (iii) and inserting a semicolon;

(B) in clause (iv), by striking ''a subsequent year'' and inserting ''1996 and 1997'', and

(C) by adding at the end the following new clauses:

''(v) for each of the years 1998 through 2002, 1 percent, and

''(vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;''.

(c) PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the

charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995.

SEC. 4612. OXYGEN AND OXYGEN EQUIPMENT.

Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1993, 1994, 1995, 1996, and 1997'', and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new clauses:

''(v) in each of the years 1998 through 2002, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

''(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.''.

SEC. 4613. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by inserting ''and 1998 through 2002'' after ''1995''.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking ''and'' at the end;

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1998,'' after ''1995,'', and

(B) by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following new clause:

''(viii) after December 31, 1997, is equal to 72 percent of such median.''.

SEC. 4614. SIMPLIFICATION IN ADMINISTRATION OF LABORATORY TESTS.

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory tests (other than for tests performed in physician offices) furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary may select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY TESTS.—

(1) IN GENERAL.—Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title

XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—The policies under paragraph (1) shall be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN CARRIER REQUIREMENTS PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM REGIONAL POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be imple-

mented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national standards of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) NOTICE.— Before a carrier implements a change or policy under paragraph (3), (4), or (5), the carrier shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 4615. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by striking all that follows ''shall be increased'' and inserting the following: ''as follows:

''(i) For fiscal years 1996 and 1997, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

''(ii) For each of fiscal years 1998 through 2002 by such percentage increase minus 2.0 percentage points.

''(iii) For each succeeding fiscal year by such percentage increase.''.

SEC. 4616. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

''(o) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 4617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended, is amended by inserting after subparagraph (S) the following new subparagraph:

''(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer

chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

"(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

"(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.".

(b) PAYMENT LEVELS.—Section 1834 (42 U.S.C. 1395m), as amended by sections 4421(a)(2) and 4431(b)(2), is amended by adding at the end the following new subsection:

"(m) SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.—

"(1) LIMITATION ON PER DOSE PAYMENT BASIS.—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied during 1996.

"(2) AGGREGATE LIMIT.—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part does not result in any increase in aggregate payments per capita under this part above the levels of such payments per capita that would otherwise have been made if there were no coverage for such drugs under this part.

"(3) ORAL ANTI-NAUSEA DRUGS DEFINED.—For purposes of this subsection, the term 'oral anti-nausea drugs' means drugs for which coverage is provided under this part pursuant to section 1861(s)(2)(P).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4618. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''independent rural health clinics'' and inserting ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting ''per visit'' after ''$46''.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

''(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period at the end the following: '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking ''and that is designated'' and inserting ''and that, within the previous three-year period, has been designated''; and

(B) by striking ''or that is designated'' and inserting ''or designated''.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after ''personal health services''; and

(B) by inserting ''and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),'' after ''Bureau of the Census)''.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least one month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health

clinics under title XVIII of the Social Security Act on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least one month after enactment of this Act.

SEC. 4619. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;".

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and'' after ''are performed,''; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''clauses (i) or (iii) of subsection (s)(2)(K)'' and inserting ''subsection (s)(2)(K)''.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 10401(a), is amended by striking ''through (iii)'' and inserting ''and (ii)''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and''.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural

area)'' and inserting ''section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)'';

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking ''section 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)(ii)''; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking ''clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)'' and inserting ''section 1861(s)(2)(K)(i) (relating to physician assistants)''.

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))'' and inserting ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services''.

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking ''clauses (i), (ii), or (iv)'' and inserting ''clause (i)''; and

(B) by striking ''or nurse practitioner''.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.— Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting ''(A)'' after ''(5)'';

(2) by striking ''The term 'physician assistant' '' and all that follows through ''who performs'' and inserting ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs''; and

(3) by adding at the end the following new subparagraph:

''(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

''(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 4620. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended—

(1) by striking ''(I) in a hospital'' and all that follows through ''shortage area,'', and

(2) by adding at the end the following: ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 4619(b)(2)(B), is amended to read as follows:

''(12) With respect to services described in section 1861(s)(2)(K)(i)—

''(A) payment under this part may only be made on an assignment-related basis; and

''(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.''.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: ''For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 4621. RENAL DIALYSIS-RELATED SERVICES.

(a) AUDITING OF COST REPORTS.—The Secretary shall audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter.

(b) IMPLEMENTATION OF QUALITY STANDARDS.—The Secretary of Health and Human Services shall develop and implement, by not later than January 1, 1999, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act in order to reduce payments for inappropriate or low quality care.

SEC. 4622. PAYMENT FOR COCHLEAR IMPLANTS AS CUSTOMIZED DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(h)(1)(E) (42 U.S.C. 1395m(h)(1)(E)) is amended by adding at the end the following: ''Payment for cochlear implants shall be made in accordance with subsection (a)(4), and, in applying such subsection to cochlear implants, carriers shall take into consideration technological innovations and data on charges to the extent that such charges reflect such innovations.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to implants implanted on or after January 1, 1998.

CHAPTER 3—PART B PREMIUM

SEC. 4631. PART B PREMIUM.

(a) IN GENERAL.—The first, second and third sentences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are amended to read as follows: ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year. That monthly premium rate shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'',

(B) in the last sentence of subsection (a)(3)—

(i) by inserting ''rate'' after ''premium'', and

(ii) by striking ''and the derivation of the dollar amounts specified in this paragraph'',

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking ''or 1839(e), as the case may be''.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

SEC. 4701. PERMANENT EXTENSION AND REVISION OF CERTAIN SECONDARY PAYER PROVISIONS.

(a) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

(1) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(A) in the first sentence, by striking ''12-month'' each place it appears and inserting ''30-month'', and

(B) by striking the second sentence.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to items and services furnished on or after the date of the enactment of this Act and with respect to periods beginning on or after the date that is 18 months prior to such date.

(c) IRS-SSA-HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

SEC. 4702. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity

required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to items and services furnished after 1990. The previous sentence shall not be construed as permitting any waiver of the 3-year-period requirement (imposed by such amendment) in the case of items and services furnished more than 3 years before the date of the enactment of this Act.

SEC. 4703. PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment'', and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) CLARIFICATION OF BENEFICIARY LIABILITY.—Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON BENEFICIARY LIABILITY.—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of the enactment of this Act.

CHAPTER 2—HOME HEALTH SERVICES

SEC. 4711. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 4712. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before the comma at the end;

(3) in subclause (II), by striking '', or'' and inserting ''of such mean,'';

(4) in subclause (III)—

(A) by inserting ''and before October 1, 1997,'' after ''July 1, 1987,'', and

(B) by striking the comma at the end and inserting ''of such mean, or''; and

(5) by striking the matter following subclause (III) and inserting the following:

''(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 4711(a), is amended by inserting adding at the end the following new clauses:

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

''(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during 1994, and based 25 percent on the standardized regional average of such costs for the agency's region for cost reporting periods ending during 1994, such costs updated by the home health market basket index; and

''(II) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

''(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year

1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.''.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 4713. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional cir-

cumstances when the need for additional care is finite and predictable).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 4714. STUDY ON DEFINITION OF HOMEBOUND.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 4715. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

SEC. 4716. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS,

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 4103(c), is amended—

(1) by striking ''and'' at the end of subparagraph (G),

(2) by striking the semicolon at the end of subparagraph (H) and inserting '', and'', and

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;''.

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medicare program pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 4717. NO HOME HEALTH BENEFITS BASED SOLELY ON DRAWING BLOOD.

(a) IN GENERAL.—Sections 1814(a)(2)(C) and 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) are each amended by inserting ''(other than solely venipuncture for the purpose of obtaining a blood sample)'' after ''skilled nursing care''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to home health services furnished after the 6–month period beginning after the date of enactment of this Act.

SEC. 4718. MAKING PART B PRIMARY PAYOR FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1833(d) (42 U.S.C. 1395l(d)) is amended—

(1) by striking ''(d) No'' and inserting ''(d)(1) Subject to paragraph (2), no'', and

(2) by adding at the end the following new paragraph:

''(2) Payment shall be made under this part (rather than under part A), for an individual entitled to benefits under part A, for home health services, other than the first 100 visits of post-hospital home health services furnished to an individual.''.

(b) POST-HOSPITAL HOME HEALTH SERVICES.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following:

''(ss) POST-HOSPITAL HOME HEALTH SERVICES.—The term 'post-hospital home health services' means home health services furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than 3 consecutive days before discharge, or during a covered post-hospital extended care stay, if home health services are initiated for the individual within 30 days after discharge from the hospital, rural primary care hospital or extended care facility.''.

(c) PAYMENTS UNDER PART B.—Subparagraph (A) of section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk)), and to items and services described in section 1861(s)(10)(A), the amounts determined under section 1861(v)(1)(L) or section 1893, or, if the services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge, or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(d) PHASE-IN OF ADDITIONAL PART B COSTS IN DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(1) in paragraph (3) in last the sentence inserted by section 4631(a) of this title, by inserting ''(except as provided in paragraph (5)(B))'' before the period, and

(2) by adding after paragraph (4) the following:

''(5)(A) The Secretary shall, at the time of determining the monthly actuarial rate under paragraph (1) for 1998 through 2003, shall determine a transitional monthly actuarial rate for enrollees age 65 and over in the same manner as such rate is determined under paragraph (1), except that there shall be excluded from such determination an estimate of any benefits and administrative costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (2) of section 1833(d).

''(B) The monthly premium for each individual enrolled under this part for each month for a year (beginning with 1998 and ending with 2003) shall be equal to 50 percent of the monthly actuarial rate determined under subparagraph (A) increased by the following proportion of the difference between such premium and the monthly premium otherwise determined under paragraph (3) (without regard to this paragraph):

''(i) For a month in 1998, 1/7.

''(ii) For a month in 1999, 2/7.

''(iii) For a month in 2000, 3/7.

''(iv) For a month in 2001, 4/7.

''(v) For a month in 2002, 5/7.

''(vi) For a month in 2003, 6/7.''.

(e) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting ''(or $100 in the case of home health services)'' after ''$500''.

(f) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit a report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the impact on home health utilization and admissions to hospitals and skilled nursing facilities of the amendment made by subsection (b). The Secretary shall further reex-

amine and submit a report to such Committees on this impact 1 year after the full implementation of the prospective payment system for home health services into the medicare program, effected under the amendments made by section 4441.

(g) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

SEC. 4721. BIPARTISAN COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT.—There is established a commission to be known as the Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(C) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(D) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(E) The role medicare should play in addressing the needs of persons with chronic illness.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 voting members as follows:

(A) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(B) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(C) The 3 ex officio members of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet level officials.

(2) CHAIRMAN AND VICE CHAIRMAN.—As the first item of business at the Commission's first meeting (described in paragraph (5)(B)), the Commission shall elect a Chairman and Vice Chairman from among its members. The individuals elected as Chairman and Vice Chairman may not be of the same political party and may not have been appointed to the Commission by the same appointing authority.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (f).

(5) MEETINGS.—

(A) The Commission shall meet at the call of its Chairman or a majority of its members.

(B) The Commission shall hold its first meeting not later than February 1, 1998.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) ADVISORY PANEL.—

(1) IN GENERAL.—The Chairman, in consultation with the Vice Chairman, may establish a panel (in this section referred to as the ''Advisory Panel'') consisting of health care experts, consumers, providers, and others to advise and assist the members of the Commission in carrying out the duties described in subsection (b). The panel shall have only those powers that the Chairman, in consultation with the Vice Chairman, determines are necessary and appropriate to assist the Commission in carrying out such duties.

(2) COMPENSATION.—Members of the Advisory Panel are not entitled to receive compensation for service on the Advisory Panel. Subject to the approval of the chairman of the Commission, members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Advisory Panel.

(e) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions

of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(f) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(g) REPORT.—Not later than May 1, 1999, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(h) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (g).

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

CHAPTER 4—PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

SEC. 4731. LIMITATION ON PAYMENT BASED ON NUMBER OF RESIDENTS AND IMPLEMENTATION OF ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

"(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program may not exceed the number of full-time equivalent residents with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

"(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

"(i) FY 1998.—For the hospital's first cost reporting period beginning during fiscal year 1998, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital's graduate medical education payment, shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding cost reporting period.

"(ii) SUBSEQUENT YEARS.—For each subsequent cost reporting period, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital's graduate medical education payment, shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and preceding two cost reporting periods.

"(iii) ADJUSTMENT FOR SHORT PERIODS.—If a hospital's cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full 12-month cost reporting periods.

"(iv) EXCLUSION OF RESIDENTS IN DENTISTRY.—Residents in an approved medical residency training program in dentistry shall not be counted for purposes of this subparagraph and subparagraph (F).".

SEC. 4732. PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT OF DIRECT MEDICAL EDUCATION COSTS.

(a) IN GENERAL.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended—

(1) in subparagraph (B), by inserting "subject to subparagraph (D)," after "subparagraph (A)", and

(2) by adding at the end the following:

"(D) PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT.—

"(i) IN GENERAL.—In the case of a hospital for which the overhead GME amount (as defined in clause (ii)) for the base period exceeds an amount equal to the 75th percentile of the overhead GME amounts in such period for all hospitals (weighted

to reflect the full-time equivalent resident counts for all approved medical residency training programs), subject to clause (iv), the hospital's approved FTE resident amount (for periods beginning on or after October 1, 1997) shall be reduced from the amount otherwise applicable (as previously reduced under this subparagraph) by an overhead reduction amount. The overhead reduction amount is equal to the lesser of—

"(I) 20 percent of the reference reduction amount (described in clause (iii)) for the period, or

"(II) 15 percent of the hospital's overhead GME amount for the period (as otherwise determined before the reduction provided under this subparagraph for the period involved).

"(ii) OVERHEAD GME AMOUNT.—For purposes of this subparagraph, the term 'overhead GME amount' means, for a hospital for a period, the product of—

"(I) the percentage of the hospital's approved FTE resident amount for the base period that is not attributable to resident salaries and fringe benefits, and

"(II) the hospital's approved FTE resident amount for the period involved.

"(iii) REFERENCE REDUCTION AMOUNT.—

"(I) IN GENERAL.—The reference reduction amount described in this clause for a hospital for a cost reporting period is the base difference (described in subclause (II)) updated, in a compounded manner for each period from the base period to the period involved, by the update applied for such period to the hospital's approved FTE resident amount.

"(II) BASE DIFFERENCE.—The base difference described in this subclause for a hos-

pital is the amount by which the hospital's overhead GME amount in the base period exceeded the 75th percentile of such amounts (as described in clause (i)).

"(iv) MAXIMUM REDUCTION TO 75TH PERCENTILE.—In no case shall the reduction under this subparagraph effected for a hospital for a period (below the amount that would otherwise apply for the period if this subparagraph did not apply for any period) exceed the reference reduction amount for the hospital for the period.

"(v) BASE PERIOD.—For purposes of this subparagraph, the term 'base period' means the cost reporting period beginning in fiscal year 1984 or the period used to establish the hospital's approved FTE resident amount for hospitals that did not have approved residency training programs in fiscal year 1984.

"(vi) RULES FOR HOSPITALS INITIATING RESIDENCY TRAINING PROGRAMS.—The Secretary shall establish rules for the application of this subparagraph in the case of a hospital that initiates medical residency training programs during or after the base period.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to per resident payment amounts attributable to periods beginning on or after October 1, 1997.

SEC. 4733. PERMITTING PAYMENT TO NON-HOSPITAL PROVIDERS.

(a) IN GENERAL.— Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following:

"(k) PAYMENT TO NON-HOSPITAL PROVIDERS.—

"(1) REPORT.—The Secretary shall submit to Congress, not later than 18 months after the date of the enactment of this subsection, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of an ap-

proved medical residency training program described in subsection (h). Such proposal shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

''(2) EFFECTIVENESS.—Except as otherwise provided in law, the Secretary may implement such proposal for residency years beginning not earlier than 6 months after the date of submittal of the report under paragraph (1).

''(3) QUALIFIED NON-HOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified non-hospital provider' means—

''(A) a Federally qualified health center, as defined in section 1861(aa)(4);

''(B) a rural health clinic, as defined in section 1861(aa)(2); and

''(C) such other providers (other than hospitals) as the Secretary determines to be appropriate.''.

(b) PROHIBITION ON DOUBLE PAYMENTS; BUDGET NEUTRALITY ADJUSTMENT.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents and, in the case of residents not included in any such count, the Secretary shall provide for such a reduction in aggregate approved amounts under this subsection as will assure that the application of subsection (k) does not result in any increase in expenditures under this title in excess of those that would have occurred if subsection (k) were not applicable.''.

SEC. 4734. INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.

Section 1886(h) (42 U.S.C. 1395ww(h)) is further amended by adding at the end the following new paragraph:

''(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

''(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

''(i) amount (if any) by which—

''(I) the amount of payment which would have been made under this subsection if there had been a 5 percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the qualifying entity as of June 30, 1997, exceeds

''(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

''(ii) the amount of the reduction in payment under 1886(d)(5)(B) (for hospitals participating in the qualifying entity) that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of such entity as of June 30, 1997.

''(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

''(i) the application is submitted in a form and manner specified by the Secretary and by not later than March 1, 2000,

"(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

"(iii) the entity elects in the application whether such reduction will occur over—

"(I) a period of not longer than 5 residency training years, or

"(II) a period of 6 residency training years,

except that a qualifying entity described in subparagraph (C)(i)(III) may not make the election described in subclause (II); and

"(iv) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

"(C) QUALIFYING ENTITY.—

"(i) IN GENERAL.—For purposes of this paragraph, any of the following may be a qualifying entity:

"(I) Individual hospitals operating one or more approved medical residency training programs.

"(II) Subject to clause (ii), two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

"(III) Subject to clause (iii), a qualifying consortium (as described in section 4735 of the Balanced Budget Act of 1997).

"(ii) ADDITIONAL REQUIREMENT FOR JOINT PROGRAMS.—In the case of an application by a qualifying entity described in clause (i)(II), the Secretary may not approve the application unless

the application represents that the qualifying entity either—

"(I) in the case of an entity that meets the requirements of clause (v) of subparagraph (D) will not reduce the number of full-time equivalent residents in primary care during the period of the plan, or

"(II) in the case of another entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

"(iii) ADDITIONAL REQUIREMENT FOR CONSORTIA.—In the case of an application by a qualifying entity described in clause (i)(III), the Secretary may not approve the application unless the application represents that the qualifying entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

"(D) RESIDENCY REDUCTION REQUIREMENTS.—

"(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i)(I), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

"(I) If base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

"(II) Subject to subclause (IV), if base number of residents exceeds 500, but is less than 750, residents, by 150 residents.

"(III) Subject to subclause (IV), if base number of residents does not exceed 500 resi-

dents, by a number equal to at least 25 percent of such base number.

"(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

"(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i)(II), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

"(I) Subject to subclause (II), by a number equal to at least 25 percent of such base number.

"(II) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

"(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(i)(III), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of such base number.

"(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than—

"(I) the 5th residency training year in which the application under subparagraph (B) is effective, in the case of an entity making the

election described in subparagraph (B)(iii)(I), or

"(II) the 6th such residency training year, in the case of an entity making the election described in subparagraph (B)(iii)(II).

"(v) ENTITIES PROVIDING ASSURANCE OF MAINTENANCE OF PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

"(I) the base number of residents for the entity is less than 750;

"(II) the number of full-time equivalent residents in primary care included in the base number of residents for the entity is at least 10 percent of such base number; and

"(III) the entity represents in its application under subparagraph (B) that there will be no reduction under the plan in the number of full-time equivalent residents in primary care.

If a qualifying entity fails to comply with the representation described in subclause (III), the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

"(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term 'base number of residents' means, with respect to a qualifying entity operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent cost reporting period ending before June 30, 1997, or, if less, for any subsequent cost reporting period that ends before the date the entity makes application under this paragraph.

"(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the 'applicable hold harmless percentage' is the percentages specified in clause (ii) or clause (iii), as elected by the qualifying entity in the application submitted under subparagraph (B).

"(ii) 5-YEAR REDUCTION PLAN.—In the case of an entity making the election described in subparagraph (B)(iii)(I), the percentages specified in this clause are, for the—

"(I) first and second residency training years in which the reduction plan is in effect, 100 percent,

"(II) third such year, 75 percent,

"(III) fourth such year, 50 percent, and

"(IV) fifth such year, 25 percent.

"(iii) 6-YEAR REDUCTION PLAN.—In the case of an entity making the election described in subparagraph (B)(iii)(II), the percentages specified in this clause are, for the—

"(I) first residency training year in which the reduction plan is in effect, 100 percent,

"(II) second such year, 95 percent,

"(III) third such year, 85 percent,

"(IV) fourth such year, 70 percent,

"(V) fifth such year, 50 percent, and

"(VI) sixth such year, 25 percent.

"(F) PENALTY FOR INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a qualifying entity, if the entity (or any hospital operating as part of the entity) increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

"(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.".

(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

(1) Section 1886(h)(6) of the Social Security Act, added by subsection (a), shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997. The Secretary of Health and Human Services shall take such actions as may be necessary to assure that (in the manner described in subparagraph (A) of such section) in no case shall payments be made under such a project with respect to the first 5 percent reduction in the base number of full-time equivalent residents otherwise used under the project.

(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

(3) A demonstration project described in this paragraph is a project that provides for additional payments under title XVIII of the Social Security Act in connection with reduction in the number of residents in a medical residency training program.

(c) INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act.

SEC. 4735. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the Secretary) shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A Federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(I) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

SEC. 4736. RECOMMENDATIONS ON LONG-TERM PAYMENT POLICIES REGARDING FINANCING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act and in this section referred to as the ''Commission'') shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be reformed. Such recommendations shall include recommendations regarding each of the following:

(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism.

(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII of the Social Security Act.

(3) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

(A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and

(B) whether and to what extent payments are being made (or should be made) for training in the various nonphysician health professions, including social workers and psychologists.

(4) Federal policies regarding international medical graduates.

(5) The dependence of schools of medicine on service-generated income.

(6) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(7) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

(c) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

(1) deans from allopathic and osteopathic schools of medicine;

(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

(4) individuals with leadership experience from representative fields of non-physician health professionals;

(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

(6) individuals with expertise on the financing of health care.

(d) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.

SEC. 4737. MEDICARE SPECIAL REIMBURSEMENT RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5)(G) (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking ''and (iii)'' and inserting '', (iii), and (iv)''; and

(2) by adding at the end the following:

''(iv) SPECIAL RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

''(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency programs for residency years beginning on or after July 1, 1998.

CHAPTER 5—OTHER PROVISIONS

SEC. 4741. CENTERS OF EXCELLENCE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following:

"CENTERS OF EXCELLENCE

"SEC. 1889. (a) IN GENERAL.—The Secretary shall use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services may include any services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

"(b) QUALITY STANDARDS.—

"(1) IN GENERAL.—Only entities that meet quality standards established by the Secretary shall be eligible to contract under this section. Contracting entities shall implement a quality improvement plan approved by the Secretary.

"(2) PARTICIPATION DECISION BASED ON QUALITY.—Subject to subsection (c), the Secretary shall consider quality as the primary factor in selecting hospitals or other entities to enter into contracts under this section.

"(c) PAYMENT.—Payment under this section shall be made on the basis of negotiated all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under a contract shall not exceed the aggregate amount of the payments that the Secretary would have otherwise made for the services.

"(d) CONTRACT PERIOD.—A contract period shall be 3 years (subject to renewal), so long as the entity continues to meet quality and other contractual standards.

"(e) INCENTIVES FOR USE OF CENTERS.—Entities under a contract under this section may furnish additional services

(at no cost to an individual entitled to benefits under this title) or waive cost-sharing, subject to the approval of the Secretary.

''(f) LIMIT ON NUMBER OF CENTERS.—The Secretary shall limit the number of centers in a geographic area to the number needed to meet projected demand for contracted services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 4742. MEDICARE PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF PART B LATE ENROLLMENT PENALTY AND MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD FOR CERTAIN MILITARY RETIREES AND DEPENDENTS.

(a) MEDICARE PART B SPECIAL ENROLLMENT PERIOD; WAIVER OF PART B PENALTY FOR LATE ENROLLMENT.—

(1) IN GENERAL.—In the case of any eligible individual (as defined in subsection (c)), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under part B of title XVIII of the Social Security Act. Such period shall be for a period of 6 months and shall begin with the first month that begins at least 45 days after the date of the enactment of this Act.

(2) COVERAGE PERIOD.—In the case of an eligible individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

(3) WAIVER OF PART B LATE ENROLLMENT PENALTY.—In the case of an eligible individual who enrolls during the special enrollment period provided under paragraph (1), there shall be no increase pursuant to section 1839(b) of the Social Security Act in the monthly premium under part B of title XVIII of such Act.

(b) MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD.—Notwithstanding any other provision of law, an issuer of a medicare supplemental policy (as defined in section 1882(g) of the Social Security Act)—

(1) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', or ''F'' under the standards established under section 1882(p)(2) of the Social Security Act (42 U.S.C. 1395rr(p)(2)); and

(2) may not discriminate in the pricing of the policy on the basis of the individual's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability;

in the case of an eligible individual who seeks to enroll (and is enrolled) during the 6-month period described in subsection (a)(1).

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term ''eligible individual'' means an individual—

(1) who, as of the date of the enactment of this Act, has attained 65 years of age and was eligible to enroll under part B of title XVIII of the Social Security Act, and

(2) who at the time the individual first satisfied paragraph (1) or (2) of section 1836 of the Social Security Act—

(A) was a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), and

(B) did not elect to enroll (or to be deemed enrolled) under section 1837 of the Social Security Act during the individual's initial enrollment period.

The Secretary of Health and Human Services shall consult with the Secretary of Defense in the identification of eligible individuals.

SEC. 4743. COMPETITIVE BIDDING FOR CERTAIN ITEMS AND SERVICES.

(a) ESTABLISHMENT OF DEMONSTRATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and operate over a 2-year period a demonstration project in 2 geographic regions selected by the Secretary under which (notwithstanding any provision of title XVIII of the Social Security Act to the contrary) the amount of payment made under the medicare program for a selected item or service furnished in the region shall be equal to the price determined pursuant to a competitive bidding process which meets the requirements of subsection (b).

(b) REQUIREMENTS FOR COMPETITIVE BIDDING PROCESS.—The competitive bidding process used under the demonstration project under this section shall meet such requirements as the Secretary may impose to ensure the cost-effective delivery to medicare beneficiaries in the project region of items and services of high quality.

(c) DETERMINATION OF SELECTED ITEMS OR SERVICES.—The Secretary shall select items and services to be subject to the demonstration project under this section if the Secretary determines that the use of competitive bidding with respect to the item or service under the project will be appropriate and cost-effective. In determining the items or services to be selected, the Secretary shall consult with an advisory taskforce which includes representatives of providers and suppliers of items and services (including small business providers and suppliers) in each geographic region in which the project will be effective.

Subtitle I—Medical Liability Reform

CHAPTER 1—GENERAL PROVISIONS

SEC. 4801. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle governs any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to an action for damages aris-

ing from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

(b) PREEMPTION.—This subtitle shall preempt any State or applicable Federal law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State or applicable Federal law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of chapter 97 of title 28, United States Code;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4802. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DEVICE.—The term ''device'' has the same meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(7) DRUG.—The term ''drug'' has the same meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(8) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from harm (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State or Federal law.

(9) HARM.—The term ''harm'' means—

(A) any physical injury, illness, or death of the claimant, or

(B) any mental anguish or emotional injury to the claimant caused by or causing the claimant physical injury or illness.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the

claimant alleges that harm was caused by the provision of (or the failure to provide) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual, organization, or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) MANUFACTURER.—The term ''manufacturer'' means—

(A) any person who is engaged in a business to produce, create, make, or construct any product (or component part of a product) and who (i) designs or formulates the product (or component part of the product), or (ii) has engaged another person to design or formulate the product (or component part of the product);

(B) a product seller, but only with respect to those aspects of a product (or component part of a product) which are created or affected when, before placing the product in the stream of commerce, the product seller produces, creates, makes or constructs and designs, or formulates, or has engaged another person to design or formulate, an aspect of the product (or component part of the product) made by another person; or

(C) any product seller not described in subparagraph (B) which holds itself out as a manufacturer to the user of the product.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of society and companionship, injury to reputation, humiliation, and other subjective, nonpecuniary losses.

(15) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(16) PRODUCT SELLER.—

(A) IN GENERAL.—The term ''product seller'' means a person who in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or otherwise is involved in placing a product in the stream of commerce; or

(ii) installs, repairs, refurbishes, reconditions, or maintains the harm-causing aspect of the product.

(B) EXCLUSION.—The term ''product seller'' does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the lessor does not initially select the leased product and does not during the lease term ordinarily control the daily operations and maintenance of the product.

(17) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Common-

wealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territories of the Pacific Islands, and any other territory or possession of the United States or any political subdivision of any of the foregoing.

SEC. 4803. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle.

CHAPTER 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 4811. STATUTE OF LIMITATIONS.

(a) GENERAL RULE.—Except as provided in subsection (b), a health care liability action may be filed not later than 2 years after the date on which the claimant discovered or, in the exercise of reasonable care, should have discovered—

(1) the harm that is the subject of the action; and

(2) the cause of the harm.

(b) EXCEPTION.—A person with a legal disability (as determined under applicable law) may file a health care liability action not later than 2 years after the date on which the person ceases to have the legal disability.

(c) TRANSITIONAL PROVISION RELATING TO EXTENSION OF PERIOD FOR BRINGING CERTAIN ACTIONS.—If any provision of subsection (a) or (b) shortens the period during which a health care liability action could be otherwise brought pursuant to another provision of law, the claimant may, notwithstanding subsections (a) and (b), bring the health care liability action not later than 2 years after the date of enactment of this Act.

SEC. 4812. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for harm which is the subject of a health

care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) FAIR SHARE RULE FOR NONECONOMIC DAMAGES.—

(A) GENERAL RULE.—In a health care liability action, the liability of each defendant for noneconomic damages shall be several only and shall not be joint.

(B) AMOUNT OF LIABILITY.—

(i) IN GENERAL.—Each defendant shall be liable only for the amount of noneconomic damages attributable to the defendant in direct proportion to the percentage of responsibility of the defendant (determined in accordance with paragraph (2)) for the harm to the claimant with respect to which the defendant is liable. The court shall render a separate judgment against each defendant in an amount determined pursuant to the preceding sentence.

(ii) PERCENTAGE OF RESPONSIBILITY.—For purposes of determining the amount of noneconomic damages attributable to a defendant under this section, the trier of fact shall determine the percentage of responsibility of each person responsible for the claimant's harm, whether or not such person is a party to the action.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable law, be awarded in a health care liability action against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was result of conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) REQUIRED PROPORTIONALITY.—The amount of punitive damages that may be awarded in a health care liability action shall not exceed 3 times the amount of dam-

ages awarded to the claimant for economic loss, or $250,000, whichever is greater. This subsection shall be applied by the court, and application of this subsection shall not be disclosed to the jury.

(c) BIFURCATION AT REQUEST OF ANY PARTY.—

(1) IN GENERAL.—At the request of any party the trier of fact in any action that is subject to this section shall consider in a separate proceeding, held subsequent to the determination of the amount of compensatory damages, whether punitive damages are to be awarded for the harm that is the subject of the action and the amount of the award.

(2) INADMISSIBILITY OF EVIDENCE RELATIVE ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PROCEEDING CONCERNING COMPENSATORY DAMAGES.—If any party requests a separate proceeding under paragraph (1), in a proceeding to determine whether the claimant may be awarded compensatory damages, any evidence, argument, or contention that is relevant only to the claim of punitive damages, as determined by applicable law, shall be inadmissible.

(d) DRUGS AND DEVICES.—

(1)(A) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or device which caused the claimant's harm where—

(i) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm or the adequacy of the packaging or labeling of such drug or device, and such drug or device was approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(B) Subparagraph (A) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(i) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(ii) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(2) PACKAGING.—In a health care liability action which is alleged to relate to the adequacy of the packaging (or labeling relating to such packaging) of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer of the drug shall not be held liable for punitive damages unless the drug is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(e) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceed $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, with the amount and schedule of such payments determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time

to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(f) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If a defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action. This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4813. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.